

**Maternal and Child  
Health Services Title V  
Block Grant**

**Pennsylvania**

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## I. General Requirements

### I.A. Letter of Transmittal



July 15, 2015

Ms. Michele H. Lawler, M.S., R.D.  
Acting Director  
Division of State and Community Health  
Maternal and Child Health Bureau  
Health Resources and Services Administration  
Room 5C-26, Parklawn Building  
5600 Fishers Lane  
Rockville, MD 20857

Dear Ms. Lawler:

This letter and Application for Federal Assistance Form 424 are formal notification that the Pennsylvania Department of Health wishes to continue administrative responsibility for the Title V Maternal and Child Health Services Block Grant in Federal Fiscal Year 2016. As directed, Pennsylvania's 2014 Annual Report and 2016 Application have been submitted electronically via EHB, HRSA's electronic handbook.

I look forward to your final approval of our request. Please contact Sara Thuma, MCH Block Grant Coordinator, at [sthuma@pa.gov](mailto:sthuma@pa.gov) with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Carolyn S. Cass', written over a faint horizontal line.

Carolyn S. Cass  
Acting Director  
Bureau of Family Health

I certify that the financial information contained in this application is true and accurate to the best of my knowledge.

A handwritten signature in black ink, appearing to read 'Terri A. Matio', written over a faint horizontal line.

Terri A. Matio  
Chief Financial Officer

## **I.B. Face Sheet**

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

## **I.C. Assurances and Certifications**

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

## **I.D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

## **I.E. Application/Annual Report Executive Summary**

Administered by the Bureau of Family Health (BFH) within the Pennsylvania (PA) Department of Health (DOH), the Title V grant provided over 230,000 services through 28 programs across the six defined population domains in 2014.

The BFH is tasked with continuously determining the best ways to serve the MCH populations while balancing the dynamic nature of political and social will within the sixth most populous state in the nation. Through the needs assessment process the BFH conducts an in-depth analysis of the health of the MCH population and an examination of the social, economic, political and environmental spheres that intersect and shape the lives of the population. This process also requires the BFH to examine its capacity to build relationships with partners; use data; make decisions regarding the allocation of human, programmatic, and financial resources; and innovatively evolve programming.

The revelations of the current needs assessment, combined with the transformation of the grant have created the perfect opportunity for the BFH to alter its character and current programmatic vision to one more science, logic and data driven in order to continue working towards improving the health of the MCH population. Many of the priorities that emerged out of the needs assessment have a broad scope that crosses domains enabling the BFH to address multiple aspects of the MCH population with varied programming. The following discusses BFH accomplishments and future plans for each of the six defined domains.

In the 2010 needs assessment, the BFH priorities for the women/maternal health domain included: decreasing barriers for prenatal care for at-risk/uninsured women through implementation of best practices; and increasing behavioral health screening, diagnosis, and treatment for pregnant women and mothers. Performance measures specific to this domain were: percentage of women who smoke in the last three months of pregnancy; and percent of women with live birth whose observed to expected prenatal visits are greater than or equal to 80 percent of the Kotelchuck index. For both measures, the annual indicators improved each year and BFH met the stated objectives.

In the 2015 needs assessment, the BFH determined a shift in focus from prenatal care to preconception and interconception care was needed to address behaviors and risk factors during this critical life stage before they have a negative effect on the mothers and infants resulting in a new priority: adolescents and women of child-bearing age have access to and participate in preconception and interconception health care and support. This priority is linked with national performance measure (NPM) 1: percent of women with a past year preventive medical visit. The BFH has defined two objectives to address this priority and NPM and plans to expand current programming and implement innovative interconception care initiatives in order to increase the percent of women who discuss birth

spacing and birth control with a health professional and engage in family planning after a delivery.

During the 2010 needs assessment, the BFH identified reducing the infant mortality rate as a priority. In addition, the BFH implemented activities to address the following national and state performance measures: The percent of screen positive newborns who received timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs; The percent of mothers who breastfeed their infants at 6 months of age; Percentage of newborns who have been screened for hearing before hospital discharge; Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The state is meeting or exceeding its objectives with regard to newborn screening. While breastfeeding rates are achieving their defined objectives, rates are still low compared to other states and the nation.

During the 2015 needs assessment, three perinatal/infant health priorities emerged: Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants; Safe sleep practices are consistently implemented for all infants; and appropriate health and health related services, screenings and information are available to the MCH population.

Two of these priorities are linked with NPMs: NPM 4, percent of infants who are ever breastfed and percent of infants breastfed exclusively through 6 months; and NPM 5, percent of infants placed to sleep on their backs. The third priority in this domain supports continued newborn screening with an objective to decrease the time between screening test and receipt time at the contracted lab. Receipt times will be tracked and quality assurance measures and training implemented if needed.

Increasing the proportion of PA birthing facilities providing recommended care for breastfeeding mothers and babies, increasing the breastfeeding rates in counties with a rate below 73 percent, integrating breastfeeding information into other programming, and implementing breastfeeding promotion media opportunities are all objectives that will be addressed through the expansion while integrating new programming and messaging opportunities.

While the safe sleep priority is new, previous safe sleep initiatives were related to a former priority addressing injury prevention. Strong agency and stakeholder support combined with infant mortality and safe sleep behavior data indicated a need for this priority. The BFH has two objectives aimed at changing sleep behaviors: decrease the rate of mothers who report sleeping with their baby during the first year of life; and decrease the percentage of infants who are strangled or suffocated due to unsafe sleep environments. Efforts will focus on a combination of hospital initiatives and new safe sleep strategies.

State priorities in the 2010 needs assessment cycle addressing child health were: increase screening for mental health issues among infants, children, and adolescents; and expand injury prevention activities for infants, children, and adolescents. Screenings were provided through home visiting programs. Little to no decrease was observed in the indicators for child injury over the last five years.

Through the 2015 needs assessment, it was apparent a broader priority was needed to address the child population but with a narrower scope as other bureaus also work on injury prevention. The following priority emerged: MCH populations reside in a safe and healthy environment. Within the domain of child health, this priority is linked to NPM 7: percent of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescent ages 10 through 19. Increasing the number of homes receiving home assessments; increase the number of MCH stakeholders who receive education on healthy homes practices; and disseminate three simple and clear messages

about the dangers of prescription drugs are all objectives to be addressed. Efforts will focus on home and safety assessments and messaging combined with injury prevention interventions.

For the 2010 needs assessment cycle, the priorities and performance measures that addressed the needs of the CSHCN population included: improving the transition from child to adult medical, educational, and social services; increasing respite services for caregivers; improving family partnerships in decision-making for CSHCN and overall satisfaction with care; receiving coordinated, ongoing, comprehensive care within a medical home; obtaining adequate insurance coverage for needed services; improving access to a well-functioning community-based system; and receiving needed referrals for specialty care/services without a problem. The BFH met all the indicators defined for this population domain.

Through the 2015 needs assessment, the BFH decided to expand the scope of the priority for CSHCN to include all families as some aspects of care and system navigation are not specific to families of CSHCN: Appropriate health and health related services, screenings and information are available to the MCH population. For the CSHCN domain, this priority is linked with NPM 11: Percent of children with and without special health care needs having a medical home. With the understanding that the diverse needs of families of CSHCN can be met through medical homes, the BFH has decided to focus its resources on increasing the number of fully implemented medical homes across the state following the defined standards for medical homes.

In the 2010 needs assessment cycle, state priorities that addressed adolescent health included: decrease teen pregnancy through comprehensive sex education; expand injury prevention activities, including suicide prevention; and expand access to physical and behavioral health services for high risk youth, including lesbian, gay, bisexual, transgender and questioning (LGBTQ) and runaway/homeless. Teen pregnancy rates across the state are decreasing with annual indicators exceeding the yearly targets, while suicide rates may be increasing for this population.

As a result of the 2015 needs assessment, the BFH decided to define the following broad priority to move away from narrowly focusing on a specific risk behavior: Protective factors are established for adolescents and young adults prior to and during critical life stages. Protective factors are individual or environmental characteristics, conditions or behaviors that reduce the effects of stressful life events. This priority is linked with one NPM: NPM 9, percent of adolescents, ages 12 through 17, who are bullied or who bully others. Objectives and strategies will focus on increasing bullying awareness and prevention programming for all adolescents with additional cultural competency training and policy development for vendors specifically regarding LGBTQ youth. Additionally, the BFH has defined objectives to increase the number of LGBTQ sensitive organizations which provide services to youth; increase the number of LGBTQ youth who have access to suicide prevention services; increase the number of mentoring, counseling and adult supervision programs available to youth ages 9-14; and increase the number of youth who report achieving developmental assets.

The BFH priority of adolescents and women of child-bearing age have access to and participate in preconception and interconception health care and support will be linked within this domain to NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. The four objectives for this priority and NPM are to increase the number of counties with Health Resource Center (HRC) available to youth ages 12-17 either in a school or community-based setting; increase the number of youth ages 12-17 utilizing the HRC services; increase the number of LGBTQ youth with a medical visit in the past year; and increase the number of youth receiving health education and counseling services during a reproductive health visit.

In the prior needs assessment cycle, there were no priorities that specifically addressed the life course perspective,

but the BFH has implemented several initiatives that cut across more than one population domain. In addition, while many programs or services focus on a single population domain, the services that are offered work to either increase protective factors or reduce risk factors and may mitigate some of the multiple stressors that a family faces. BFH has also provided education and some training to staff and partners about the Life Course Perspective as it relates to maternal, infant, and child health outcomes. BFH has supported the implementation of preconception and interconception health programs that begin to address social determinants of health in order to improve health outcomes.

As a result of the 2015 needs assessment several priorities emerged that did not fit one particular population domain. While two of these are new, the below-mentioned screening priority replaces the prior state priority to increase behavioral health screening, diagnosis and treatment for pregnant women and mothers (including postpartum depression).

The priority defined as women receiving prenatal care are screened for behavioral health and referred for assessment if warranted is linked to NPM 14: A) Percent of women who smoke during pregnancy and B) percent of children living in households where someone smokes. Decreasing the percentage of women who smoke during pregnancy and decreasing the percentage of women who report smoking after pregnancy are the objectives to address this NPM. Objectives to increase the number women screened for behavioral health and increase the percentage of women who discuss intimate partner violence with their home visitor will also be addressed. An integrated screening tool combined with motivational interviewing will be used address these objectives.

Health literacy impacts all of the population domains and is important in the types of service delivery. The BFH saw a need for increasing health literacy which led to the creation of the following priority: MCH populations are able to obtain, process, and understand basic health information needed to make appropriate health decisions. The BFH will disseminate at least one simple and clear message about basic health information through the evaluation of various social media and text messaging pathways.

The final priority crosses all domains: Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs. Through the needs assessment, the BFH discovered its data resources were not being thoroughly used to inform decision-making and evaluate population and programmatic needs. Therefore, several objectives have been defined to annually identify at least one area of improvement in collecting or using data; annually conduct analysis to develop actionable goals; programs with actionable findings will develop and implement at least one programmatic strategy based upon the findings; and existing data collection programs will increase the dissemination of data to improve health outcomes. By focusing on data for this grant cycle, the BFH will make changes in procedures and processes to institutionalize best practices for a successful future.

Transformation does not come without challenges. The BFH was challenged by the new structure of Title V grant and anticipates further challenges in the implementation phase, but was invigorated by the new possibilities of programming and an expanded vision for improving health that emerged out of the process. With a clearly defined action plan for the new priorities, the BFH is looking forward to expanding the reach and impact of Title V services for the MCH population of PA in the next five years and beyond.

## II. Components of the Application/Annual Report

### II.A. Overview of the State

Understanding the needs of the MCH population in Pennsylvania (PA) first requires knowledge of the geographical, political, social and economic characteristics of the Keystone state and its residents. Located in the Northeast, PA is home to over 12.7 million people and is the sixth most populous state. The Appalachian Mountains run through the center of the state creating a large swath of rural forest area dividing the state in half. Additionally, several major interstates crisscross the state making it not only a destination but an important transitory point for those traveling throughout the Northeast and beyond.

The urban counties anchor the state around Pittsburgh in the west and Philadelphia in the east. Urban counties are those with a population density higher than the state population density, while rural are lower. Harrisburg, the capital and headquarters for the Department of Health (DOH), is situated in the southcentral part of the state. Seven of the nation's 100 largest metropolitan areas are located in PA. Sixteen metro areas contain 84 percent of the state's population, 87 percent of the job share and 92 percent of the state's gross domestic product. Further, the top six metropolitan areas—Philadelphia, Pittsburgh, Harrisburg/Carlisle, the Lehigh Valley, Scranton/Wilkes-Barre/Hazleton, and Lancaster—alone generate the bulk of the state's innovation, contain over three-quarters of the state's educated workforce, and serve as transport hubs. With the 6<sup>th</sup> largest economy in the nation, PA has an unemployment rate lower than the national average. The health care, social assistance, manufacturing and real estate sectors are major contributors to the economy.

In 2013, the 157 general acute care hospitals, including 13 Critical Access Hospitals, with over 35,000 licensed beds handled almost 1.5 million admissions. An additional 90 federal and specialty hospitals handled over 180,000 admissions. A portion of these hospitals are trauma centers. Primarily located in the 19 urban counties, they are accessible by almost all residents within 60 minutes via air or ground transportation. However, access drops dramatically without the use of helicopters. Supplementing the hospitals are over 250 Federally Qualified Health Centers or Rural Health Centers providing primary care services in 48 counties with 40 percent in rural counties. Act 315, Pennsylvania's Local Health Administration Law, mandates DOH to provide funding for MCH services in the six county and four municipal health departments.

The delivery of health care services is significantly impacted by the distinctive rural and urban characteristics across the state. While the majority of the 67 counties are rural, over 70 percent of the population, including the greatest density of ethnic minorities, lives in the 19 that are urban. These urban counties employ 93 percent of the physicians who practice direct patient care. This results in a rate of physicians who practice direct patient care at 226 practicing physicians per 100,000 population in urban counties and a rate of 134 practicing physicians per 100,000 population in rural counties. In addition to a general lack of healthcare resources, rural areas have other challenges: an aging population; a growing young minority population with higher rates of poverty and unemployment; and a lack of resources or training to meet the language and cultural needs of the growing immigrant populations.

Intersecting with the disparities created by geography are the varied backgrounds of the people that bring a unique combination of cultural norms, life experiences, and perceptions to their interaction with the health care system. With the total minority population projected to double between 1990 and 2025, the responsibility and challenge of the Title V program is to have an understanding of these backgrounds and how they combine to shape interactions with services and programming in order for Title V to meet immediate needs and reduce health disparities over the long-term.

African Americans have the highest overall mortality rates compared to all other racial groups following the national trend. They are more likely to live in urban areas with food deserts, high fast food concentrations and high crime areas with little access to parks and recreational areas. Access to care is a significant problem, although the introduction of the new health care law may mitigate this problem. African Americans are also disproportionately underrepresented in the medical community; the majority of licensed physicians in PA are white. So if access is not a problem, the inability to speak with a professional from one's own community creates additional barriers to improving health. White doctors are unlikely to counsel black patients on weight and exercise often due to negative perceptions and a lack of sensitivity to their health challenges. Cultural constructs surrounding body image and attractiveness also define how and when this community interfaces with the health care system with regard to obesity and related illnesses. These barriers, combined with pre-existing low levels of trust in the healthcare system, may continue to contribute to racial disparities in health outcomes.

Despite living under similar socioeconomic conditions, and having similar cultural attitudes with regard to body image, Hispanics have lower overall death rates than blacks. Nearly three-quarters of a million people comprise the Hispanic population which is becoming increasingly diverse in heritage. Obstacles Hispanics encounter when obtaining health care are cost, language barriers and issues surrounding the stigma of seeking help from a mental health professional.

Increases in immigration and high fertility rates in certain communities are changing the face of health care consumers. In the last decade, the Pacific Islander population doubled and the Asian population increased almost 60 percent with this trend projected to continue. As this population is largely defined, it is important to examine the potential for disparities and differences within groups including different generational attitudes towards death, family duty, information disclosure, decision-making, and use of mental health services. Educational attainment varies between communities. Religious traditions, cultural barriers, fear of stigma, and deeply held healthcare beliefs shape the relationship of Asian American populations and the health care system. Fear of deportation, waiting periods for Medicaid eligibility, limited English language proficiency, and previous maternal and pediatric health challenges before entering the U.S. also contribute to the use of available services. Undocumented immigrants entering with the possibility of undetected contagious diseases, increases the burden on the health care system which can create a significant impact on the economic and physical health of the state.

Refugee admissions into the state have been increasing with over three thousand arriving in 2011 from 57 different countries. Refugees are being forced from their homes and have little choice as to when and where they resettle. Major obstacles for this population include finding employment due to language barriers and housing due to lack of options. For refugees and immigrants, accessing health care services is hindered by language, cultural barriers, potential stigma, low health literacy, and the myriad of stressors associated with pre-and post-migration.

The degree of acculturation can positively or negatively affect health outcomes. Second-generation immigrants, generally more acculturated than first-generation immigrants, have a greater risk for substance abuse and poor birth outcomes yet are more likely to use preventive and clinical health care.

Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) residents face ongoing health inequities in terms of their absence in statewide surveillance systems, discrimination by healthcare providers, in the workplace, and in social situations. Over half of LGBTQ individuals have reported discrimination at some point based solely on sexual orientation which remains legal in PA. There are few laws protecting LGBTQ families with regard to insurance coverage, hospital visitation rights, and powers of attorney. Members of LGBTQ groups have health needs both regular and specific to their sexual and gender orientation that often go unmet.

Threatening situations including unsafe school environments and intimate partner violence are constant realities for

LGBTQ individuals and can contribute to other risky behaviors. LGBTQ teenagers are significantly more likely to engage in skipping school for fear of personal safety; attempt suicide; make a suicide plan; use tobacco, alcohol and other drugs; engage in unsafe sexual behaviors; and manage weight in an unhealthy way. As many as 25 percent of LGBTQ teenagers who come out are rejected by their families and find themselves homeless increasing their likelihood of experiencing violence either on the street or in the shelter system.

Large disparities exist in the incarcerated population in three main ways: incarceration rates are much higher for people of color; mental illness impacts a significantly higher proportion of the incarcerated population than the general population; and female prisoners have not only a higher overall rate of mental illness but suffer more adverse consequences. Moreover, all incarcerated individuals are at increased risk for infections due to a variety of factors, yet have little access to appropriate health care including the reproductive care needed by the 25 percent of women pregnant or postpartum when they enter prison. The majority of women in jail are mothers, usually the primary caretaker or wage-earner, extending the adverse effects of incarceration to the health of the children of these women.

Mental illness encompasses a wide range of disorders and can be as disabling as cancer or other chronic diseases. Prevalence of mental health issues in children has been increasing though this may be related to more accurate diagnosis. Mental illness is particularly difficult from a policy standpoint as mental illness presents differently between individuals, may lack a precise definition, cuts across policy and service areas which requires multi-faceted solutions and coordination across agencies and providers.

People with disabilities may have multiple barriers to performing daily life functions including finding physical pathways to community locations and the need for eating and dressing accommodations. Individuals with physical disabilities often have higher levels of poverty and unemployment while those with mental illness are more likely to abuse illicit drugs and/or alcohol and constitute a large portion of the homeless population; all barriers to accessing and using health care services. It is often hard for individuals with disabilities to find a therapist who has cultural competence and experience with their disability. Access to treatment is particularly hard for those with mental illness with issues related to how to get to treatment, treatment plan compliance, the burden of stigmatization, and cost.

Overlapping the aforementioned disparities are familial, educational, and economic characteristics of the population that further define their interaction with the health care system. According to 2013 estimates, the median age of PA residents is 41 years old with counties varying from 29 to 51 years old; three years older than the national median age. The state population is aging and ranks fourth in the U.S. by percentage of the population age 65 and older and by number and percent of population age 85 and older. It is estimated that by 2020, the population of those 60 and older will be over a quarter of the state population. Factors and behaviors beginning in the childhood years are substantially determining the chronic diseases present in the aging population. Improving the health of today's children will directly impact the care and resources needed for future elder care.

Of the approximately 4.9 million households in the state, only about 30 percent have one or more people under the age of 18. Over 3.1 million of these households are defined as families with an average size of 3.13 members. Families are categorized by the U.S. Census Bureau into three types: married-couple families, male householder (no wife present), and female householder (no husband present). While married families are the majority, almost three-quarters of non-married families are female led. These households have slightly larger family sizes and are more likely to have one or more members less than 18 years of age.

The PA marriage equality law was passed on May 20, 2014. According to 2010 Census data, analyzed by The Williams Institute, there are 22,336 same-sex couples in PA, and 16 percent of those couples are raising children.

A closer look at heterosexual married couples indicates over half have both the husband and wife in the labor force. When these families have children under 18, even more of these couples are working. This increase of householders in the workforce when there are children is consistent across family types except for two instances: the proportion of male householders in the workforce stays the same regardless of the presence of children and the percentage of married families with only the wife working decreases when there are children under 18.

The population of children under age 18 is fairly evenly distributed across age groups for each family type. Of the 2.7 million children in the state, almost 1.8 million live in a married family; over 196,000 children live in male led families; and 709,000 children live in female led families. Not only do more children reside in female led families as compared to male, but these households are half as likely as male led families to have an unmarried partner present.

The racial distribution greatly varies between types of households with children. While almost 84 percent of children in married families are identified as white, 70 percent of children in male led families and a little more than 50 percent of children in female led families identify as white. Female led families have the greatest percentage of children identifying as black or Hispanic as compared to all other households. While married families with children have relatively few other children—defined as grandchildren, other relatives, foster child or other unrelated child—almost 20 percent of children in both male and female led families are categorized as being “an other” child.

The median income varies by county from \$36,600-\$86,000 with the median income for families with children within this range at \$66,156. However, when stratified by family type, the numbers are very different with the median income for married families at almost \$90,000, approximately \$41,000 for male led families and \$24,000 for female led families. Although female led families are slightly larger than the other types, their median income is nearly half the next highest median income. This income gap is exacerbated by the wage gap. Women in PA are earning slightly less (76.4 cents) than the national average for women (78.3 cents) to every dollar a man makes. The wage gap is even greater if the woman is a minority.

This economic disparity is further displayed by the percentage of children living in households who received public assistance in the last twelve months. Statewide 28 percent of children lived in households that received public assistance in the last 12 months. Both female led families at nearly 60 percent and male led families at 35 percent are above the statewide rate while married families at 14 percent are below. For children in households for whom poverty status is determined, female led families were almost two times more likely than male led families and more than six times more likely than married families to have income in the past twelve months below the poverty level. Female led families are at quite an economic disadvantage compared to other families in the state which limits the health resources and capacity of these women to care for themselves and their children.

An understanding of the state’s educational attainment gives a glimpse of the potential earning status of current and future residents. Of the approximately 1.25 million of 18 to 24 year olds, 32 percent have graduated high school; 44 percent are enrolled in college or graduate school and 11 percent have a bachelor’s degree or higher. Males in this age group are enrolled in college or graduate school at a slightly lower rate than females.

For the 8.8 million people aged 25 years and over, over 89 percent are high school graduates or higher although this varies a bit by county, and almost 29 percent have a bachelor’s degree or higher. For this same population, for whom poverty status is determined, the rate of poverty for those with less than a high school diploma is 26 percent and decreases with educational attainment. The median income for those aged 25 years and older is \$36,000 and ranges from almost \$22,000 for those with less than a high school diploma or equivalency to almost \$65,000 for graduate or professional degree holders.

Of the approximately 1.4 million families with related children under 18 years in 2013, 16 percent were living below

the poverty level during the previous twelve months. The highest proportion of families living below the poverty level was the female led families: a rate two or more times the married or state poverty rates. For all categories of families, those with a householder having less than a high school education had the highest rates of poverty. However, at all levels of educational attainment, the percentage of female led families living below the poverty level was almost three times that of the state. The greater the number of children and number of people in a family, the higher the proportion of families living below the poverty level. In contrast, the more workers there are in the family the lower the proportion of families living below the poverty level. The greatest economic obstacles and burdens fall on female led families as they have lower incomes, higher rates of poverty despite educational attainment, and have larger family units not appearing to include unmarried partners.

In 2013, over 141,000 of the almost 3 million women aged 15 to 50 had a birth in the previous 12 months which equates to a rate of 48 women with births per 1,000 women, with almost 39 percent of these women being unmarried.

Age Group	# of women with births per 1,000 women	% of women unmarried
15 to 19 year olds	19	94%
20 to 34 year olds	86	41%
35 to 50 year olds	22	15%

Table 1 shows a decrease in the percentage of women unmarried as age increases. Further, the highest rate of women with births is in the 20 to 34 year old age group which is almost four times the rate of the other age groups. While nearly half of these women were unmarried, there is the possibility that other adults or an unmarried partner are present in the lives of these mothers and children. Further exploration of women with births in the last twelve months reveals the following:

- Women identified as “some other race” had the highest rate of women with births while whites had the lowest rate.
- Black women comprised the highest portion of women who had a birth and were unmarried.
- Foreign born women had a higher rate of women with births, but were half as likely to be unmarried as compared to native born women.
- As educational attainment increased, the rate of women with births increased and the percentage of women with births who were unmarried decreased.
- There was a decrease in both the rate of women with births and percentage unmarried as income moved away from the poverty level.
- The rate of women with births receiving public assistance was more than double the rate of those with births who did not receive assistance.
- Three quarters of those receiving public assistance were unmarried.

An important sub-population within the MCH population is adolescents (15 to 19 years) who number an estimated

854,000 with almost 90 percent enrolled in school. The percentage in school varies by race with Hispanic adolescents having the lowest enrollment at 83 percent. Almost 5 percent of black and 6 percent of Hispanic adolescents had a birth in the past 12 months compared to less than one percent of whites. Almost 60 percent of black adolescents and 44 percent of Hispanics live in female led families while 70 percent of whites live in married families. The remainder lives in non-family or male led families. The percentage in the labor force ranges from 35 percent for black adolescents to 43 percent for whites.

Health insurance is a key criterion for healthcare access. The distribution of residents with at least one type of insurance is as follows:

<b>Type of Insurance</b>	<b>% of residents</b>
Private	72%
Employment-based	60%
Direct Purchase	14%
TRICARE	1%
Public	32%
Medicare	18%
Medicaid/means-tested public	16%
VA	2%

Of the approximately 12.6 million noninstitutionalized people, almost 10 percent were uninsured in 2013. Nearly 90 percent of the uninsured population was 18 to 64 years old despite being only 62 percent of the total population. Specifically, the largest subset of uninsured was 25 to 34 year olds. The overwhelming majority of the uninsured population is white and native born. However blacks, Hispanics, and foreign born individuals make up a higher percentage of the uninsured population than in the total population. The majority of those uninsured were not disabled; three-quarters were in the labor force with almost 60 percent employed. The greatest percentage of uninsured were employed in arts/entertainment and recreation and accommodation and food services; educational services/health care/social assistance; and retail trade. In the past year, 33 percent worked full-time year round and 79 percent of the uninsured were private for-profit wage and salary employees. The median earnings of the uninsured population were \$16,917, practically half the median earnings of the state. The proportion of the population of uninsured decreased as income increased; however, nearly 60 percent of the uninsured population had a household income under \$49,999, with only 24 percent at or above 300 percent of the poverty level for those whom poverty status was determined.

The Affordable Care Act (ACA) has brought some insurance relief, but PA did not set up a state-based marketplace and is currently participating in the federal marketplace. As of February, 2015, over 470,000 consumers selected or were automatically re-enrolled in coverage through the marketplace; 40 percent of which were new enrollees. Over half of the enrollees obtained coverage for \$100 or less after tax credits. The number of issuers and health plans in the marketplace increased between 2014 and 2015. Of the plan selections in the state, 34 percent were by residents under the age of 35.

Medicaid expanded under the ACA and PA is one of 29 states adopting the expansion. Former Gov. Corbett implemented the Medicaid expansion over the course of 2014 through a waiver as opposed to launching the expansion on January 1, 2014. Coverage under the waiver became effective on January 1, 2015; however newly

elected Gov. Wolf withdrew the waiver and is implementing a traditional Medicaid expansion called Health Choices which should be completed by September 30, 2015. Since the marketplace's first open enrollment period, almost 108,000 have gained CHIP or Medicaid coverage with children accounting for over half the enrollment as of January 2015. The expansion of Medicaid is expected to result in an estimated \$16.5 billion in additional Medicaid federal funds from 2014-2020 and is projected to lead to additional billions in economic activity.

Over 1.7 million women and 1.1 million children living with cancer or other chronic diseases no longer have to worry about lifetime limits on insurance coverage. The ACA prevents denial of insurance coverage because of pre-existing conditions; women no longer have to pay more because they are women; and there is expanded mental health and substance use disorder benefits. Over 3.3 million, more than 1.3 million women, gained preventive service coverage with no cost-sharing. The state has also received over \$5 million to help fight unreasonable premium increases.

The number of National Health Service Corps clinicians providing primary care services has increased, and PA Health Center grantees have received over \$189 million to broaden their services. Over \$6.5 million was awarded to help enroll the uninsured in the marketplace. Through FY2013, the Prevention and Public Health Fund created by the ACA has given over \$45 million in grants to PA for a variety of initiatives aimed at improving the health of the people.

With a new administration comes new health leadership and fresh vision for the DOH. The Secretary of Health and the Physician General are focusing on increasing school immunizations and better tracking of the immunization status of students. Like other states the epidemic of prescription drug and heroin use is another priority drawing a lot of public and DOH attention. Addressing this problem has taken precedence since the new administration began in January of this year. Other priorities to be addressed are expanding access to care in under-served areas of the state and promoting healthy lifestyles. In the governor's proposed budget, the highlighted priorities include health innovation; creation of a Marcellus Shale Health Registry; creation and operation of a state prescription drug monitoring program; the reopening of state health centers that were closed as part of the prior administration's modernization plan; and the expansion of mandatory newborn screenings. The proposed health budget is a 2.1 percent increase in funding over FY2014 for total proposed budget of \$864 million.

In addition to the areas of need identified by the new leadership, the DOH is in the planning stages for the 2015-2019 State Health Improvement Plan (SHIP). The results of this process could illuminate hidden issues and avenues of service relevant to the MCH population. The SHIP priorities are: 1) behavioral and mental health for adults and children, drug and alcohol abuse; 2) obesity, physical inactivity, and nutrition; 3) preventive screenings, and 4) primary care. The DOH is also in the process of preparing to submit a letter of intent to the Public Health Accreditation Board to apply for accreditation. Both of these processes can help the BFH improve collaborations between staff and stakeholders and further the Title V mission and programming through increased accountability and quality service delivery.

Other emerging issues influencing Title V services in the state surround interpreter access, provider shortages and a women's health agenda. The DOH's Office of Health Equity is trying to clarify how interpretation services can be accessed through Medicaid since the five languages available do not currently meet the needs of the refugee population. Of increasing concern is a growing provider shortage identified through the 155 defined Medically Underserved Areas/Populations, the 159 primary care Health Professional Shortage Areas (HPSA), the 116 mental health and the 160 dental HPSAs resulting in unmet needs for care. While the state ranks 5<sup>th</sup> in the nation for the ratio of medical residents per 100,000 population, the state ranks 38<sup>th</sup> in percentage of physicians completing graduate medical education in the state and then remaining to practice. In an effort to close the provider gap, proposed legislation would allow nurse practitioners to run their own practices without physician oversight and join 19 other states with similar requirements.

The state legislature is also taking a stand for women's health with a bipartisan caucus supporting the "Pennsylvania Agenda for Women's Health," a legislation package that touches on a variety of issues from improving working conditions for women and mothers, closing pay equity loopholes, extending sexual harassment protections, safe access to healthcare facilities, and preventing gender violence on campuses. As the Title V administrator, the BFH will stay abreast of these policy initiatives and the political and social temperament surrounding their success or failure to better understand current political and social will and the potential programming impacts.

The BFH must find balance between addressing pertinent issues in the public eye, filling the holes in the health services gap, and expanding the public health infrastructure and services groundwork needed to decrease disparities and increase the health of the MCH population. The BFH is continuously evolving and expanding its focus to innovatively address not only specific public health problems, but also increase awareness of the social determinants of health for the MCH population while accommodating the agenda of the DOH as a whole.

## **II.B. Five Year Needs Assessment Summary**

### **II.B.1. Process**

Pennsylvania (PA) conducted a State Health Assessment (SHA) in 2013 to assess and report on the health status of the population. This assessment, published in March 2014, is part of a department-wide process to apply for national accreditation by the Public Health Accreditation Board. The SHA is the basis for the creation of the state health improvement plan currently in the final stages of development. The SHA was a collaborative process of collecting and analyzing data and information to develop priorities and policies, garner resources and plan actions to improve the population's health. It was conducted in partnership with 50 outside organizations and includes data and information on demographics; socioeconomic characteristics; quality of life; behavioral factors; the environment; morbidity and mortality; and other determinants of health.

A core committee made up of Department of Health (DOH) staff performed the majority of the work to carry out the assessment with planning and assistance from a consultant firm. An advisory committee, consisting of 125 members representing a broad array of state public health systems including various state agencies, colleges and universities, and organizations/associations was created. In addition to the committees, individual bureaus and programs within the DOH furthered the inclusion of other stakeholders in the process. The SHA circulated for public comment from Sept. 3-Oct. 11, 2013 via the DOH website, through advisory committee distribution, Health Improvement partners and the DOH Health Statistics Bulletin.

The BFH chose to use the SHA as the backbone of the 2015 Title V Needs Assessment to assess the broad needs and capacity of the state and then gather primary data from focus groups to specifically assess MCH population stakeholder needs and capacity with regard to Title V service delivery. Existing partnerships and collaborations were also summarized. The most recent available state and national secondary quantitative data specific to the MCH population were analyzed including:

PA Bureau of Health Statistics and Research  
PA Community Health Assessment Reports  
Healthy People 2020  
US Census Bureau, American Community Survey  
PA Child Death Review Reports  
Childhood Lead Surveillance Reports  
PA Pregnancy Risk Assessment Monitoring System (PRAMS)

The SHA was the major source of secondary quantitative and qualitative data. Ten broad topic areas were covered by the SHA: the context of health in the state, general health status, major risk and protective factors, occupational health and safety, infectious diseases, injury and violence, maternal and child health, environmental health, healthcare services and chronic diseases. Both local and national data including literature review were used as sources for the SHA. Below are some of the key sources for the creation of the SHA:

CDC sources such as Youth Risk Behavior Survey & National Notifiable Disease Surveillance System  
Medicaid Statistical Information System  
PA Behavioral Risk Factor Surveillance System  
PA Cancer Registry  
PA Department of Human Services, Office of Medical Assistance Programs  
Pennsylvania Health Care Cost Containment Council

The BFH director, division directors, program managers and the Title V project coordinator comprise the Title V Block Grant committee and facilitated fifteen focus groups with various internal and external organizational/program representatives from September to December 2014. The focus groups were asked 12 questions developed internally by BFH staff with regard to the provision of Title V services. Stakeholders who were not able to participate in focus groups were invited to provide written responses to the questions. Focus group data were summarized, themes identified and then divided by population domain. Stakeholder groups were then asked via email for additional feedback on the focus group themes and requested to submit any evidence-based strategies for addressing the themes and/or the new NPMs.

Information from all the data sources was reviewed by the BFH Block Grant Committee individually and collectively. The state's chosen priority needs evolved after careful review of the SHA, subsequent data related to the MCH population, focus group responses, and BFH capacity to impact population needs. Executive staff reviewed and provided additional guidance for the priorities based on overall DOH initiatives and goals. The final priorities reflect an approach to address current population needs in light of the changing health care environment, the transformation of the Title V performance measure framework, and the mission of the DOH. Of the nine priorities selected for the population, four are broader visions of previous state priorities, and the remaining five are new visions to address the needs of the MCH population of PA.

## **II.B.2. Findings**

### **II.B.2.a. MCH Population Needs**

#### **Women/Maternal**

In 2013, there were over 6 million women living in Pennsylvania (PA) with various characteristics detailed in the table below.

2013 Pennsylvania Women	
<b>Race</b>	
83%	White
12%	Black
5%	Other
6%	Hispanic
<b>Unintended Pregnancies (2011)</b>	
38%	Mothers with an unintended pregnancy
<b>Poverty Level</b>	
14%	Below poverty level
<b>Health Insurance</b>	
12%	Uninsured
88%	Insured
<b>Educational Attainment</b>	
3%	< 9 <sup>th</sup> Grade
7%	9–12 Grade
35%	High School Graduate/GED
19%	Some College
8%	Associate Degree
17%	Bachelor's Degree
10%	Graduate or Professional Degree
<b>Employment</b>	
69%	Employed
<b>Smoking (2009-2011)</b>	
29%	Smoked cigarettes in the past two years

In 2013, 68 percent of women had a preventive medical visit in the past year with little variance seen between subgroups, with the exception the uninsured.

In 2013, there were more than 138,000 births and 73 percent of pregnant women received prenatal care beginning in the first trimester which is below the 77.9 percent Healthy People 2020 Objective. The lowest rate of prenatal care access was among uninsured women at 33 percent and it is anticipated that the Affordable Care Act (ACA) will positively impact those numbers going forward. Adequate access to prenatal care is further complicated in certain regions of the state, namely the southeast, where the hospital obstetrical capacity has declined dramatically over the last decade.

Despite the fact that rates of women receiving early and adequate prenatal care have been steadily improving, racial disparities remain with black, Hispanic and Asian and Pacific Islander women having a higher percentage of those

who did not receive prenatal care. The table below shows the rates of prenatal care in recent years.

Prenatal Care	
<b>Adequate Prenatal Care (2011)</b>	
73%	White
57%	Black
59%	Hispanic
<b>Prenatal Care in the First Trimester (2010-2012)</b>	
77%	White
56%	Black
57%	Hispanic
<b>No Prenatal Care (2010-2012)</b>	
1%	White
4%	Black
2%	Hispanic

The BFH has begun to address these issues of disparity by implementing creative initiatives, namely Centering Pregnancy, in an area of Philadelphia with historically poor birth outcomes. In 2012, the percentage of low birth weight babies enrolled in the program was slightly lower than the county average and the breastfeeding initiation rate was slightly higher. Over the long term, larger differences in positive birth outcomes are expected. The Lancaster Centering Pregnancy program also saw success with breastfeeding initiation rates at 90 percent, above the countywide rate. With this success, the BFH will continue implementing Centering Pregnancy programs.

Historically, poor birth outcomes such as the infant mortality rate, maternal mortality rate and low birth weight have been higher among blacks. From 2008 to 2012, the rate of severe maternal morbidity per 10,000 delivery hospitalizations increased from 102.1 to 128.1 with the highest rates among Medicaid and non-Hispanic blacks. Additionally, a recent report released by the Philadelphia medical examiner's office revealed a pregnancy-related mortality rate in Philadelphia of 27.4 per 100,000 live births for 2010-2012 compared to the national average of 17.8. These stark figures are a reminder to address the immediate health needs of at-risk populations and the social determinants of health prior to pregnancy.

Stakeholders identified Title V home visiting programs as a strength and an important safety net for at-risk women who would otherwise go unserved or underserved to receive vital and timely prenatal and postpartum services. The importance of addressing non-health related issues of housing, education, employment and domestic violence was identified as a need and speaks to the importance of addressing physical health as well as the social and emotional aspects of the lives of women of child-bearing age.

While current home visiting programs provide postpartum education to new mothers on a variety of topics including birth spacing, healthy infant development, nutrition, mother's health and the importance of immunization, the BFH is looking to expand these programs and for avenues to integrate innovative interconception initiatives to address the social and emotional needs of women.

The BFH continues to work with local health departments to identify pregnant women and improving access to prenatal care. Additionally, the BFH will continue to use PRAMS data to inform program and policy development to emphasize the importance of data driven, evidence based initiatives.

## Perinatal/Infants

In 2012 there were 140,873 births in PA making the total number of infants in the state 145,394. Over a third of babies born were to women enrolled in either WIC or Medicaid programs. The table below details demographic details of the infants.

2012 Pennsylvania Infants	
Gender	
51%	Male
49%	Female
Race/Ethnicity	
78%	White
15%	Black
7%	Other
10%	Hispanic

PA requires that all infants be screened for six genetic disorders at no cost and encourage parents to have their infant screened for an additional 23 disorders which may be covered by insurance and results are reported to DOH. Hearing and heart conditions are also screened for at birth and hospitals may screen for additional disorders. Of the births, 97 percent received a blood spot screen to detect metabolic defects with less than half a percent referred for diagnostic confirmatory testing. The top three genetic disorders found in PA are hearing loss, primary congenital hypothyroidism and cystic fibrosis.

The BFH's Newborn Screening program is strong including established contracts with treatment centers to assure babies with a presumptive positive screen are followed through to diagnosis. An integrated newborn metabolic screening tracking system is under development to increase efficiency to reduce programming costs as mandatory screening expands. Lysosomal Storage Disorders are the most recent additions to the mandatory panel of newborn screening tests.

The health of infants can be an indication of the nation's health and as we have seen with other populations in PA, racial disparities persist. These disparities are influenced not only by health related factors but social factors such as poverty and access to care. In 2012, the infant mortality rate for the state was 7.0 however; the rate for black infants (14.3) was nearly double the rate for Hispanic infants (7.9) and nearly triple the rate for white infants (5.2). The leading causes of infant mortality are birth defects, prematurity and low birth weight and sudden unexpected infant death (SUID).

In 2012, 10.8 percent of PA babies were born prematurely, which surpasses the Healthy People 2020 goal of 11.4 percent. The percentage of low birth weight babies was 8.1 with disparities again when stratifying the rate by race: black (12.9), Hispanic (8.5), white (7.0). Only the rate for white babies surpasses the Healthy People 2020 goal of 7.8 percent.

In 2013, the sleep related SUID rate per 100,000 live births was 83.7, a significant improvement from 88.4 in 2012. The safest place for an infant to sleep is alone in a crib on their back and in 2011, 78 percent of infants were placed on their backs to sleep.

In 2014, PA continued to fall below the national breastfeeding rates in six categories as detailed in the table below.

<b>Breastfeeding Rates</b>		
	<b>Pennsylvania</b>	<b>Nation</b>
Ever breastfed	73%	79%
Breastfeeding at 6 months	46%	49%
Breastfeeding at 12 months	26%	27%
Exclusive breastfeeding at 3 months	34%	41%
Exclusive breastfeeding at 6 months	15%	19%

While PA breastfeeding rates are increasing, there is still more work to be done including disparities between counties and sub-populations. Over the past year, 651 primary care and OB-GYN professionals received training on how to support and promote breastfeeding within their patient population with positive changes seen in provider behavior. The BFH is focused on expanding current baby-friendly hospital initiatives to support breastfeeding and integrating breastfeeding messages into other programming supported BFH and DOH.

Stakeholders identified several needs such as providing a cross systems approach including nutrition, housing and education services for the Title V population. Additional suggestions included focusing on continuity of care with a PCP; enhancing and strengthening home visiting programs; parental education related to the health and safety of infants during the prenatal and postpartum periods; and better communication between hospitals, providers and parents. The BFH is looking to address some of these concerns with more integrated and innovative programming especially during the first year of life with a focus on safe sleep.

The BFH is working on numerous initiatives to reduce infant mortality as it is related to safe sleep. Currently, the Cribs for Kids program provides portable cribs, safety education and a home safety check to families unable to afford a safe sleep environment for their infants and conducts trainings for police and emergency personnel to capitalize on their position and presence in the community.

The BFH is working to maintain and expand collaborations through safe sleep summits and ongoing Child Death Review (CDR) program work to unify investigative responses to infant death and develop consistent messaging about safe sleep practices and the prevention of death and injury. Going forward the BFH will continue to emphasize safe sleep promotion initiatives and support evidence based or informed programming aimed at decreasing the incidence of infant death due to unsafe sleep practices.

**Child**

In 2013, there were 3,081,171 children ages 0-19 in PA, 24 percent of the population, and their demographic distribution is detailed in the table below:

2013 Pennsylvania Children (ages 0-19)	
Gender	
51%	Male
49%	Female
Race/Ethnicity	
78%	White
15%	Black
4%	Asian/Pacific Islander
4%	Multi-Race
10%	Hispanic
Rural/Urban	
26%	Rural
74%	Urban
Under Poverty Level	
19%	Children under 18

Child injury and mortality are key indicators of children’s health. In 2012, the rate of hospitalization for non-fatal injury for children ages 0 through 9 was 189.7 per 100,000. The rate is higher for children ages 1-4, non-Hispanic blacks and males. Of specified causes of injuries resulting in hospitalization, falls and poisonings were in the top three leading causes for those under age 25. Hot objects were the second leading specified cause of injury hospitalizations for children under age 5. The table below details falls and poisonings as causes of injury for children up to age 25.

Hospitalizations for Injuries								
Type of Injury	Under 5		Ages 5 to 14		Ages 15-24		All Ages	
	Number	Percentage of Age Group Total	Number	Percentage of Age Group Total	Number	Percentage of Age Group Total	Number	Percentage
All Injuries	2,186	100%	2,898	100%	10,134	100%	141,130	100%
Falls	610	28%	810	28%	1,017	10%	63,477	45%
Poisoning	215	10%	241	8%	2,389	24%	15,954	11%

The child mortality rate for children ages 1-9 in was 15.5 per 100,000 in 2013 with higher rates for children ages 1-4 years, non-Hispanic blacks, males, and those living in rural areas. There is a clear disparity with regards to both injury and mortality for black children. Black children comprised 14 percent of children ages 1-17, but represented 21 percent of total child deaths and died at 1.6 times the rate of white children. Black children had higher rates of non-fatal injury (ages 0-9), child mortality (ages 1-9), and asthma prevalence (age under 18).

From 2009-2011, males accounted for 75 percent of injury related deaths in children ages 1-21 and males exceeded the number of female deaths in every subcategory of injury related death, including poisoning, overdose or acute intoxication, and for both unintentional and intentional injury. White children comprised nearly all deaths from drowning and poisoning overdose or acute intoxication.

A number of needs were identified by stakeholders: prevention services for asthma and injury, environmental health,

school-based services, confidential services, and mental health. While the BFH administers programs that address some of these needs, other needs are addressed by other bureaus and agencies. The Immunization Program and Asthma Control Program reside in other bureaus, school-based services are located within the Department of Education and mental health programs are primarily housed within the Department of Human Services (DHS).

Because these needs are addressed by programs in other areas, the BFH will focus on safe and healthy living environments for children, and programs aimed at reducing child hospitalization and mortality rates. Given the disparities that exist for black children, and for males, future programs or initiatives could address these specific populations.

The proportion of old homes in Pennsylvania presents a challenge to maintaining safe and healthy living environments. In 2010, Pennsylvania was fifth among states in the percentage of homes built before 1950 (36 percent), and as well as those built before 1978 (70 percent). In addition to presenting a risk factor in lead poisoning, an older home also has a greater probability of having a degraded structure. Structural deficiencies can lead to injury, increase the possibility of pest infestation, and contribute to an unsafe, unhealthy living environment. In 2011/12, 19 percent of PA children aged 0-17 lived in a poorly kept home, higher than the national average (16.2).

BFH has successfully implemented the Lead and Healthy Homes Program (LHHP), a primary prevention and education program that seeks to provide education on healthy homes to high risk individuals or families and provide intervention supplies to reduce hazards and promote healthy homes. BFH plans to continue the LHHP with a greater focus on injury prevention through education and interventions to parents about home issues that may present hazards to health and safety.

All of PA's 67 counties are represented by one of the state's 63 local (CDR) teams. Based on findings from child death reviews conducted by local CDR Teams, prevention measures were developed and implemented in the communities across the state addressing motor vehicle safety, suicide prevention, safe sleep and farm safety. The DCAHS will continue to administer the CDR Program and work toward expanding preventive measures and targeted programming. The DCAHS will also collaborate with the Violence and Injury Prevention Program and participate on the Injury and Violence Prevention Network, which endeavors to develop a comprehensive and coordinated injury prevention effort, to further address injury related hospitalization and death.

## **CSHCN**

CSHCN are those who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition and also require health and related services of a type or amount beyond that required by children in general. In 2009/2010, CSHCN accounted for 17 percent of PA children, an increase from 15 percent in 2005/2006. Over 245,000 PA children and adults live with a disability and special health care needs due to Traumatic Brain Injury (TBI) with an additional 8,600 sustaining long term disabilities as a result of a TBI annually.

2009/2010 Pennsylvania Children with Special Health Care Needs	
Gender	
51%	Male
49%	Female
Race/Ethnicity	
73%	White
13%	Black
6%	Other
8%	Hispanic
Poverty Level	
38%	< 200%
17%	200-299%
14%	300-399%
30%	≥ 400%
Insurance Coverage	
44%	Private only
36%	Public only
19%	Both private and public
2%	Uninsured

The BFH compares state performance to national performance on outcomes for CSHCN to determine areas of success and need. In all six core areas, PA is performing equal to or above the national outcomes as detailed in the table below.

Measure	PA (2009/2010)	Nation (2009/2010)
CSHCN who received care in a medical home	48%	43%
CSHCN who received adequate and appropriate transition services	40%	40%
Families of CSHCN who stated they were a partner in decision making at all levels	73%	70%
Families of CSHCN who found community-based services are organized and easy to use	69%	65%
Families of CSHCN who said their children were screened when needed	86%	79%
Families of CSHCN with adequate private or public insurance to pay for treatment rendered	69%	61%

While PA is performing better than the national average on the six core performance measures for CSHCN, stakeholders continue to voice the: need for more information on programs and services combined with the assistance of a navigator to walk families through the system; families' ability to determine what services are covered by Medicaid; lack of materials written in a language and at a level that families can understand; affordable and accessible transportation arrangements; and locating respite services for caregivers.

CSHCN face more barriers than other children in fulfilling aspirations related to independent living, employment, relationships and recreation. Issues involving insurance, finding doctors, managing personal health records, navigating the health care system and understanding their medical conditions. Information about services and self-advocacy skills can go a long way in helping youth be more independent in managing their health care.

Families of CSHCN have also expressed the need for programming specific to bullying. While bullying is a concern for all children, CSHCN report being bullied at a rate of 60 percent compared to 25 percent of the general population. Children with attention deficit hyperactivity disorder are not only more likely to be bullied, but are more likely to bully others. CSHCN face additional challenges such as the victim’s ability to recognize, address, and report the bullying as well as the ability of the family to detect and address bullying situations.

The BFH is already working to address these concerns through specific programming and collaboration building. Over 200,000 hours of respite care were provided to families of CSHCN by 19 trained organizations. The Special Kids Network and Medical Home Initiative (MHI) provide families of CSHCN with information to access necessary and appropriate community based services as well as connecting families of CSHCN to each other for support. The BFH offers services to all school districts to consult with school teams and families in the development and delivery of educational services for students who have experienced any type of acquired brain injury through the BrainSTEPS Program. The TBI community, through an advisory board, provides valuable expertise and unique insight to the BFH and assists with policies and procedures related to TBI.

Going forward, the MHI will be greatly enhanced to provide both CSHCN and non-CSHCN with appropriate health and health related services, screenings and information.

The BFH will continue to strengthen partnerships with advocacy organizations such as Parent to Parent, the Parent Education and Advocacy Leadership (PEAL) Center, the PA Youth Leadership Network, and the Children’s Hospital Advisory Network for Guidance and Empowerment (CHANGE) to understand and meet the needs of CSHCN.

**Adolescents**

In 2013, PA’s 1,759,480 adolescents were distributed by gender and race/ethnicity as shown in the table below.

<b>2013 Pennsylvania Adolescents (ages 10-19)</b>	
<b>Gender</b>	
51%	Male
49%	Female
<b>Race/Ethnicity</b>	
72%	White
13%	Black
3%	Asian
3%	Multi-race
8%	Hispanic

There are significant disparities in outcomes among racial and ethnic groups. In general, adolescents who are black, American Indian, or Hispanic, especially those who are living in poverty, experience worse outcomes in a variety of areas such as obesity, teen pregnancy, tooth decay and educational achievement compared to adolescents who are white. Sexually transmitted infection rates among adolescents 15-17 years of age also show a disparity by race/ethnicity, similar to teen pregnancy rates. The rates for chlamydia and gonorrhea are detailed in the table below.

2012 Chlamydia and Gonorrhea Rates for Adolescents per 100,000 population (15-17 years of age)	
Chlamydia	
340.4	White
890.4	Hispanic
4,791.2	Black
Gonorrhea	
46.8	White
92.6	Hispanic
1,397	Black

In the 2013-2014 school year there were 819,838 students PA schools with 13,945 dropouts. The distribution of these dropouts is detailed in the table below.

2013-2014 School Year Dropouts	
Gender	
58%	Male
42%	Female
Race/Ethnicity	
45%	White
32%	Black
4%	Other
19%	Hispanic

There were 28,957 delinquency-related dispositions in PA during 2013 which represent a 7 percent decrease from 2012 and a 30 percent decrease since 2009. In 2013, 17 year olds accounted for 26 percent of all dispositions, followed 16 year olds (21%) and 15 year olds (17%). White non-Hispanics were involved in 44 percent of delinquency dispositions, followed by black non-Hispanics and Hispanics. Statewide secure detention admissions have declined 17 percent since 2012 and 33 percent since 2009. Statewide, delinquency placements have declined each year since 2009, resulting in a 28 percent decrease.

For 2009-2013, 9 percent of PA adolescents reported using illicit drugs within the month prior to being surveyed which was slightly lower than the national rate. Also for 2009-2013, 18 percent of PA 12-20 year olds reported binge alcohol use within the month prior to being surveyed and higher than the national rate. In 2012-2013, 61 percent of PA adolescents perceived no great risk from drinking five or more drinks once or twice a week, similar to the national rate.

Between 2013 and 2014, PA had a 17 percent increase, the third-largest in the nation, in the number of unaccompanied adolescents who are homeless. In PA, the number of adolescents who are unsheltered increased by nearly a third at a time when the total population of unsheltered homeless decreased in the state and nation. There are increasing rates for bullying and suicide among adolescents, with increased rates among Lesbian, Gay, Bisexual, Transgender and Questioning/Queer (LGBTQ) adolescents. During the three year period from 2009-2011, intentional self-harm (suicide) was the second leading cause of death among 10 to 17 year olds. For PA's black

adolescents, the rate of death due to suicide was approximately twice the rate in black children nationally.

According to the Pennsylvania Youth Survey data from 2013, 93 percent of the survey respondents indicated they think it is wrong or very wrong to bully, however, one in five students indicated they had been bullied at school in the past year. Additionally, 14 percent of respondents indicated they had been electronically bullied in the past year.

The rates of LGBTQ adolescents bullied are even higher. According to the national GLSEN school climate survey, 56 percent of adolescents felt unsafe at school because of their sexual orientation and 38 percent because of their gender expression. In addition, 30 percent of LGBTQ students missed at least one day of school in the past month because they felt they were unsafe or were uncomfortable at school. Among LGBTQ adolescents in the past year 74 percent were verbally harassed, 36 percent were physically harassed, and 17 percent were physically assaulted due to their sexual orientation. Additionally, among LGBTQ adolescents in the past year 55 percent were verbally harassed, 23 percent were physically harassed, and 11 percent were physically assaulted because of their gender expression. The GLSEN survey also found that 62 percent of students who reported an incident of harassment or assault said that the school staff did nothing in response.

The BFH has had success in providing services to high-risk youth, including providing over 13,000 adolescents with reproductive health services, approximately 1,500 adolescents with teen pregnancy prevention programming, providing nearly 1,500 adolescents with services through a Health Resource Center (HRC), and providing over 6,000 safer sex materials (female and male condoms and dental dams) to adolescents through a HRC.

To continue with the strides made in decreasing the teen pregnancy rate and to account for the trends of bullying and suicides the BFH will focus adolescent programming on the areas of preconception and interconception health care and support and, establishing protective factors for adolescents and young adults prior to and during critical life stages. Preconception health care can improve reproductive health outcomes by promoting the health of women of reproductive age before conception therefore improving pregnancy related outcomes. Preconceptive care can significantly reduce birth defects and disorders caused by preterm birth. The goal of interconception care is to improve the outcome for the next pregnancy and reduce the health risk to future babies. These priorities will address major health issues, such as bullying, access to services for LGBTQ youth, suicide prevention, increasing protective factors for youth and preventative medical visits for youth.

### **Life Course**

While the individual components and characteristics of the MCH population are important, the social determinants of health such as access to health care services, transportation options, job availability, social supports, exposure to violence, cultural norms and economic status play a significant role in shaping the health of individuals and populations. The greater the disparity caused by these social determinants, the greater the challenges faced.

PA continues to grow with each generation becoming more diverse than the one before. With diversity comes a richness of culture and differing values which challenge people and systems to think and evolve to meet the changing needs. Growing diversity is not without its challenges however. For those who speak a language other than English at home, the disparities are great with 23 percent living below the poverty level compared to 13 percent of the total population. Expanding diversity demands new approaches and interpretations of how to provide appropriate and needed services to the MCH population.

Despite being a major transportation hub, rural areas lack transportation options and have large travel distances to health services. While urban areas have more transportation options, barriers are still common for those with disabilities and those with limited financial resources. Transportation-related barriers exist across agencies creating

ongoing obstacles for accessing services beyond those imposed by insurance status. Uninsured rates, particularly among children are very low and PA ranks significantly below the national average of uninsured. The overall health and dental health status of children continues to be better than the national average. Partnerships with Medicaid and CHIP have resulted in health insurance coverage for the MCH population. The Healthy Baby line assists women in finding both prenatal care and health insurance for themselves and their children. Additionally, the ACA has played a large role in expanding the insurance coverage of the MCH population.

The BFH is also able to capitalize on collaborations with the Medicaid dental program, the PA Dental Association, American Academy of Pediatrics and coalitions to assure that oral health care is accessible, and special efforts focus on the dental needs of CSHCN. Only 10 percent of adults in the country have the skills necessary to find, understand and process health information to make healthy decisions. Health literacy is a broad and multi-faceted need that continues to impact health in PA. Accessing and understanding services and information was identified as a need across all domains and also amongst providers themselves. Stakeholders were consistently vocal regarding the need to use technology to provide information on available resources to both stakeholders and the MCH population through effective routes and messaging. They suggested that social media and texting be used to provide information about specific conditions, initiatives, services, resources and general MCH/Title V knowledge. The BFH has lagged in developing an online presence on social media; however, the BFH will take advantage of DOH's social media accounts to better disseminate information to consumers and stakeholders. Additionally, DOH has started a health literacy coalition providing an opportunity for the BFH to jointly address health literacy across the state.

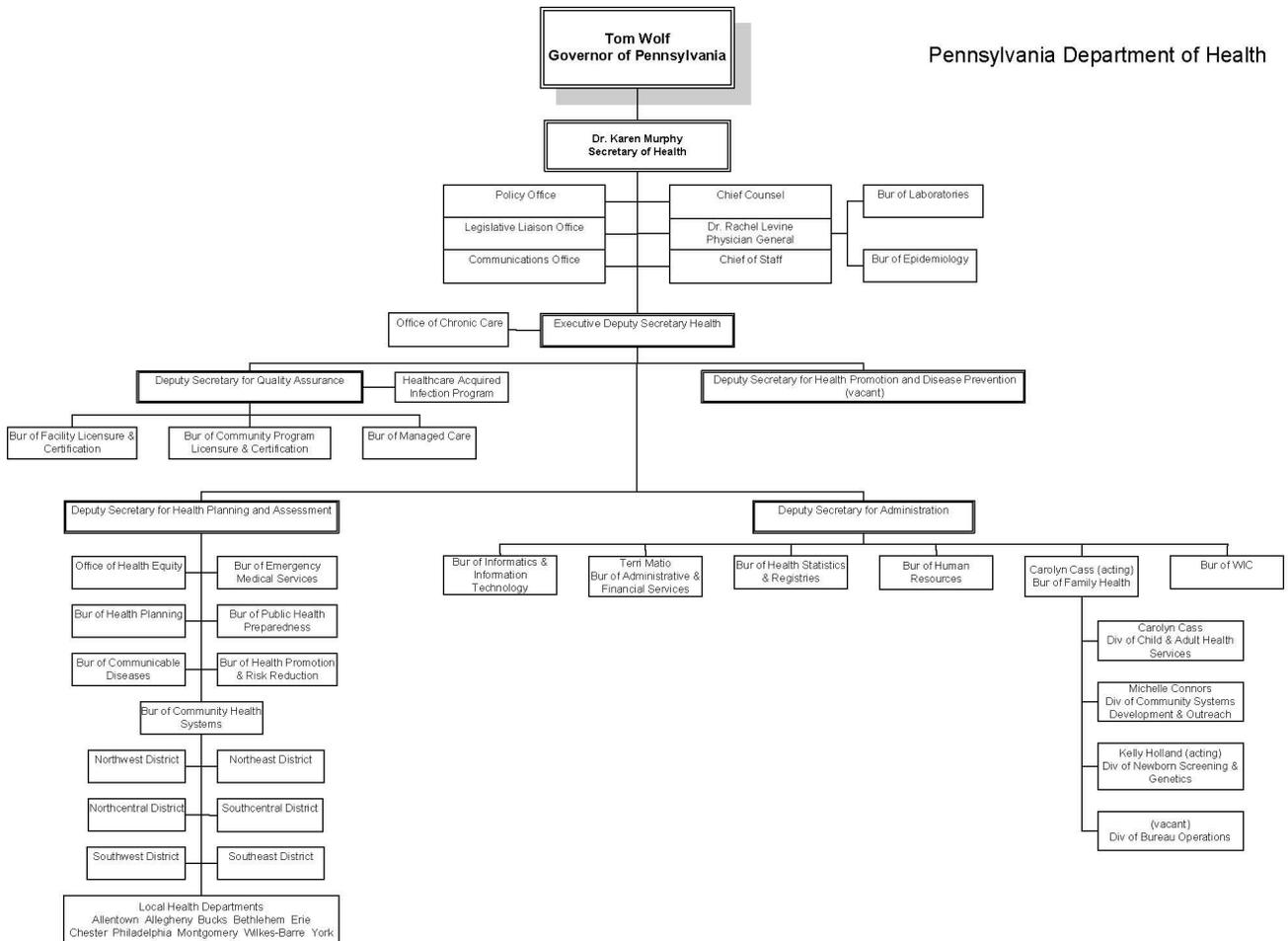
Smoking continues to have an impact on maternal and child health, despite cessation efforts. In 2013, 21 percent of the adults smoked with higher rates seen for those with less than high school education, among non-Hispanic blacks, and with incomes less than \$15,000. In 2013, 14 percent of women smoked during pregnancy a decrease from 17 percent in 2009. Higher rates were seen among women with only a high school education; who were unmarried received Medicaid; were ages 20-24 years; and who participated in WIC. In 2011-2012, 29 percent of children lived in a household where someone smoked and higher rates were found in households with CSHCN and those living below the poverty level.

Exposure to tobacco is a risk factor for the development of asthma and can trigger asthma episodes. The BFH sees a need to more directly address smoking, especially in the home, with more emphasis on screening and providing effective referrals to the 24 hour/7 day a week toll free helpline, the PA Free Quitline which provides smoking cessation information, resources and additional referrals.

The BFH is cognizant of the importance of involving nontraditional MCH organizations when addressing cross cutting and life course issues. Increasing collaborations across populations will encourage better information sharing, greater diversity of messaging, and broaden platforms needed to address the social determinants of health.

## **II.B.2.b Title V Program Capacity**

### **II.B.2.b.i. Organizational Structure**



Tom Wolf was inaugurated as the Commonwealth of Pennsylvania's 47<sup>th</sup> Governor on January 20, 2015. The Governor serves as Chief Executive of the nation's 6<sup>th</sup> most populous state. The Governor's Cabinet is comprised of the directors of various state agencies who are appointed by the Governor and confirmed by the Senate. All Cabinet members are responsible for advising the Governor on subjects related to their respective agencies.

Both Dr. Karen M. Murphy, PhD., RN, Secretary of Health, and Dr. Rachel Levine, Physician General, serve as Cabinet members. Dr. Murphy serves as the chief executive officer of the Department of Health (DOH); she sets overall policy and direction, defines the DOH's mission, establishes strategic goals and outlines specific objectives. Dr. Levine advises the Governor and the Secretary of Health on health policy and participates in the decision-making process of the DOH on policies relating to all medical and public health-related issues.

The DOH's Bureau of Family Health (BFH), as the State Title V Agency in Pennsylvania (PA), is responsible for administering a variety of MCH and CSHCN programs. The BFH's Divisions of Child and Adult Health Services (CAHS), Community Systems Development and Outreach (CSDO) and Newborn Screening and Genetics (NSG) exercise their capacity to improve the health and well-being of PA's mothers, infants, children and youth, including CSHCN, and their families.

The BFH operates 28 programs using Title V funds and administers a number of other programs using other federal and state funds. Collectively, these programs carry out the mission of the Title V Program by establishing and supporting public health services and systems, promoting and providing primary and preventive care services and ensuring access to direct health care services to MCH populations. These programs encompass direct

reimbursable services such as the Newborn Screening and Follow-up Program, non-reimbursable primary and preventative care services such as the Breastfeeding Awareness and Support Program and public health services and systems such as the Child Death Review Program. Tables 1 and 2 provide detail of these programs.

<b>Table 1: Title V Supported Programs</b>	
<b>Program / Service</b>	<b>Function(s)</b>
Reproductive Health Services	Provides family planning services, including routine gynecological care, pregnancy testing, contraceptives, cervical cancer exam, screening and treatment for sexually transmitted diseases, education and counseling, and general health screening services.
Child Death Review Program	Act 87 codified the Child Death Review (CDR) Program which is designed to promote the safety and well-being of children by reducing preventable childhood fatalities. This is accomplished through systemic, multi-agency reviews of the deaths of children under the age of 21. The CDR Program facilitates the death review process, provides training and technical assistance to local teams and makes recommendations regarding prevention programs and policies.
Shaken Baby Syndrome (SBS) Prevention and Awareness Program (Act 176 of 2002)	The SBS program is a prevention program with the goal of reducing the incidence of abusive head trauma in the Commonwealth. This program provides training, education, technical assistance and support to staff at maternity wards and neonatal intensive care units across the Commonwealth.
Local Title V Programs	Ten county municipal health departments provide a variety of services aimed at improving maternal, infant and child health across the Commonwealth. These health departments are located in Allegheny County, Allentown, Bethlehem, Bucks County, Chester County, Erie County, Montgomery County, Philadelphia, Wilkes Barre and York City. Programs provided through these health departments include: maternal home visiting, obesity prevention and education, breastfeeding education and support, health education, prenatal care, perinatal depression screening, infant and child health education and training, direct oral health services, smoking cessation.
Traumatic Brain Injury	A Statewide school re-entry program aimed at assisting schools with the re-entry issues of children and adolescents who have sustained a

<p>Traumatic Brain Injury School Re-Entry</p>	<p>Traumatic Brain Injury (TBI). This program ensures that schools are educated on the issue of TBI so that children are accurately identified and as such receive the appropriate interventions to succeed.</p>
<p>Teen Pregnancy Prevention Special Initiatives</p>	<p>Two family planning councils in the Commonwealth address teen birth and pregnancy rates through reproductive health services to high school students and two evidence-based teen pregnancy prevention interventions to middle and high school students.</p>
<p>Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth Program</p>	<p>Services to LGBTQ youth through Persad Center's Safe Spaces Project, which include suicide prevention training to youth, and engages in coalition building activities with known ally organizations and new partners to help the organizations become Safe Space certified. The Mazzone Center provides a drop-in health center for youth to obtain a variety of health care and social services.</p>
<p>Sudden Cardiac Arrest (Act 59 of 2012)</p>	<p>Primary components of the law include the requirement that parents of student athletes in the public school system must review and sign an information sheet about the warning signs and conditions of sudden cardiac arrest, training requirements for coaches, removal of a player from competition that exhibit symptoms of sudden cardiac arrest, and the requirement that the player may not return until cleared by a licensed medical professional.</p>
<p>Safety in Youth Sports Act (Act 101 of 2011)</p>	<p>The law is intended to protect student athletes from head injuries. As coaches are often the first line of defense in recognizing a concussion in athletes, the law offers tips and guidelines for recognizing and managing these injuries. Key components include establishing standards for managing concussions, removal from activity of an athlete that is suspected of suffering from a head injury, guidelines for returning an athlete to play once medical clearance is received, and required training for coaches.</p>
<p>Infant Death Program</p>	<p>The Pennsylvania Infant Death Program addresses the impact of an infant death on affected families and aims to reduce the incidence of Sudden Infant Death Syndrome (SIDS), suffocation and strangulation through public education. Key components include distribution of educational and instructional materials regarding SIDS and Sudden Unexplained Infant</p>

	Death Syndrome (SUID) and an acknowledgment statement signed by those receiving the materials.
Centering Pregnancy Programs	Group prenatal care model used to reduce healthcare disparities, promote healthy behaviors, provide peer support, improve pregnancy outcomes and reduce infant mortality.
Lead and Healthy Homes Program	The Lead and Healthy Homes Program (LHHP) is a holistic healthy homes primary prevention program. The primary activities of the LHHP are to conduct home assessments to identify factors that could contribute to injuries or illness, provide education and interventions to reduce risk factors, and develop partnerships to integrate safe and healthy housing activities with other housing and health programs. Additionally, environmental inspections are performed in homes of children with elevated blood lead levels.
Childhood Lead Surveillance	The Childhood Lead Surveillance Program monitors childhood lead testing and results through the Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS), a web-based application system that receives all lead reports submitted by laboratories. Surveillance data are used to identify possible high risk areas, areas of under-testing, and other potential service gaps. In addition to regular reporting of lead data and responses to requests, the program publishes a comprehensive annual report on lead data that includes lead testing, housing, and population data.
PA Medical Home Program (PMH)	Based on the Educating Physicians in their Communities (EPIC) model, the PMH is a statewide education and quality improvement program, using office-based change as the key to improving the care provided to Children and Youth with Special Health Care Needs (CYSHCN). The program also includes a transition component, which works to identify and place pediatric patients with special needs into adult primary care practices.
Epilepsy Support Program	Provides support services for children, youth and adults diagnosed with epilepsy/seizure disorders and their families.
Special Kids Network	Provides information and resources for Children and Youth with Special Health Care Needs (CYSHCN) and their families through 3 primary components: a toll-free helpline; in-home service coordination by an Elic

Special Kids Network	components: a toll-free helpline, in-home service coordination by an EIKS Nurse; and community engagement through Regional Coordinators, who are parents of CYSHCN.
Tourette Syndrome Support Program	Provides guidance and counseling to people with Tourette Syndrome and their families. Services include information and referral, and training for providers, parents, teachers, and other professionals.

Cystic Fibrosis Program	Hospitals across the state provide comprehensive, multidisciplinary team care to pediatric and adult patients with Cystic Fibrosis. Breathe PA is funded under this appropriation.
Sickle Cell Program	Select hospitals provide services to diagnosed patients and include diagnostic testing, transitional services, assessment, care, counseling, support, education and preventative therapeutic interventions. Community based organizations across the state provide community based services, education, and psychosocial services to patients. Services include outreach, case management, transition issues, community awareness and family support.
Children's Home Ventilator Program	Provides comprehensive care, including respite care and counseling to ventilator dependent children and families.
Child Rehabilitation Program	Hospitals and one community based organization provide comprehensive, multidisciplinary team care to clients with neuromuscular and orthopedic disorders.
Hemophilia Program	Select hospitals across the state provide multi-disciplinary team care to children and adult patients with a diagnosis of Hemophilia.
Cooley's Anemia Program	Provides comprehensive, care coordinated, multi-disciplinary team services to people of all ages with Cooley's Anemia. Services include transfusion therapy, evaluation of organ damage, specialized therapy, genetic testing, genetic counseling, chelation therapy, education and support groups.
Spina Bifida Program	Select hospitals across the state provide comprehensive, multidisciplinary team care to pediatric and adult patients with Spina Bifida.
Charcot-Marie-Tooth Program	Outreach and education about Charcot-Marie-Tooth disease.
	Breastfeeding education to primary care practices and other healthcare

Breastfeeding Awareness and Support Program	Breastfeeding education to primary care practices and other healthcare providers across the state (EPIC BEST) and a quality improvement initiative with hospitals (Keystone 10)
Newborn Metabolic Screening and Follow-up Program	This program assures screening and follow-up for 6 mandated conditions and 23 “follow-up” ensuring that blood spot specimen collection occurs as required by law, point of care testing occurs and screening results are reported for follow up through diagnosis. Follow-up services are provided on all infants with abnormal results. Newborns are referred to the appropriate treatment center to receive proper medical evaluation, confirmatory testing, diagnosis and treatment. The program contracts with treatment centers to provide newborn screening evaluations and medical services. The program manages a statewide pharmacy metabolic formula distribution system that supplies formula to diagnosed Pennsylvanians up to the age of 22 months. The program has an advisory committee comprised of subject matter experts who advise the program on best practices and also help develop follow-up protocols when new conditions are added to the screening panels.
Newborn Hearing Screening and Follow-up Program	Assures that all newborns are screened for hearing loss within the first 30 days, are diagnosed within three months, and receive prescribed treatment or intervention services within six months of birth. Newborns receive an initial hearing screening while still in the hospital. Infants who do not pass the initial screen receive follow-up re-screening at the hospital, often as an outpatient. The Department of Health performs follow-up and tracking of infants not passing their follow-up re-screening. Department staff determines whether appropriate assessment and evaluation is completed in a timely fashion and that infants receive the prescribed treatment and intervention. Infants identified as being at risk of delayed onset hearing loss receive continued monitoring as appropriate. The department also administers infant hearing screening educational outreach and training workshops for nurses, audiologists, physicians, early intervention staff, and other concerned professionals. The program has an advisory committee comprised of subject matter experts who advise the program on best practices and also help develop follow up protocols when new conditions are added to the screening panels.

<b>Table 2: Non-Title V Programs</b>	
<b>Program / Service</b>	<b>Function(s)</b>
Head Injury Program	The Head Injury Program provides services to individuals who have sustained a Traumatic Brain Injury (TBI). Services include short term rehabilitation services including cognitive and physical therapy as well as therapeutic recreation and work skills training. Additional services include pre-enrollment assistance, case management and transition services.
Traumatic Brain Injury (TBI) Grant	Through this grant the Department provides training and education to non-traditional personnel that come into contact with individuals who have sustained a TBI. These groups include mental health and drug and alcohol staff, police officers, emergency medical staff and school personnel. Through this training and education, the Department ensures that appropriate supports are in place to assist Pennsylvania residents living with TBI.
Lead Hazard Control Program (LHCP)	The LHCP utilizes certified lead abatement firms to perform lead inspection/risk assessments and lead hazard abatement on housing units of low-income families with children under age six; performs lead outreach and education; and trains contractors in lead-certified disciplines to increase the pool of certified contractors.
Pregnancy and Risk Assessment Monitoring System (PRAMS)	Mail and telephone survey concerning behaviors and attitudes of women around the time of pregnancy; Participate in the analysis of collected data; Act as a liaison with the Centers for Disease Control and Prevention on the PRAMS project.
Chronic Renal Disease	1) Provides dialysis for end stage renal disease patients who

Chronic Renal Disease Program	1) Provides dialysis for end stage renal disease patients who are enrolled in the Chronic Renal Disease Program (CRDP); 2) Provides transportation for end stage renal disease patients enrolled in the CRDP; 3) Provides prescription pharmacy drug benefit through PACE program for end stage renal disease patients enrolled in the CRDP.
Abstinence Education Program - Healthy Youth PA	The Abstinence Program (Healthy Youth PA) utilizes an approach of mentoring, counseling and adult supervision as a means of promoting abstinence from sexual activity.
Personal Responsibility Education Program (PREP)	PREP educates adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections (STIs) including HIV/AIDS, and at least three adulthood preparation subjects including: healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, and healthy life skills.
Lead Training Program	The Lead Training Program is conducted with a grant from the EPA. A contracted accredited trainer provides classes in disciplines related to inspection and abatement of lead-based paint. Students are non-profit or government employees and are not charged for classes. Upon completion of the training, students are eligible to apply for certification from the Department of Labor and Industry.

**II.B.2.b.ii. Agency Capacity**

At the state level, the BFH maintains infrastructure to support essential public health services and systems. BFH works with local Title V agencies and selects additional community based partners throughout the state, using approved procurement policies, to provide enabling or direct services to the MCH population in their communities. BFH uses population and public health data to target geographical areas for interventions, and then selects qualified grantees for the project. For all grant agreements, BFH staff develop objectives, work statements and budgets, and provide oversight and monitoring of grantee progress toward the stated goals.

## **Women/Maternal Health**

Pennsylvania's (PA) Title V program serves as an important safety net for pregnant women and women of child-bearing age. This safety net includes a variety of resources such as the training and education of MCH nurses, assisting transient mothers and their children access insurance and health care, screening new mothers for perinatal depression, providing prenatal and postpartum care and educating women on a range of topics such as birth control, substance abuse, domestic violence and healthy birth spacing. Women and mothers accessing Title V services are an inherently at-risk population by virtue of the neighborhoods in which they live, their economic situations or their medical conditions. Title V attempts to meet the needs of these women in the communities in which they reside either in partnership with local/county/municipal health departments or other community or hospital based providers.

BFH collaborates with the 10 local health departments to provide home visiting services to women who do not fit the criteria for the traditional home visiting services. Home visiting services provide education and support on health, nutrition and positive lifestyle changes for women during the prenatal and postpartum period. With realignment of funding to support the new priorities, the BFH expects to expand Nurse Family Partnership into some of the more rural counties of the state, as well as leveraging existing partnerships to provide services to more first time mothers. Additionally, Lancaster General Hospital and Albert Einstein Healthcare Network in Philadelphia, in conjunction with the BFH, offer Centering Pregnancy, a group prenatal care program shown to increase appointment compliance and knowledge of pregnancy and infant health. These programs educate women on the importance of birth spacing and interconception care.

Augmenting and supporting these collaborations is the Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance system designed to identify maternal experiences and behaviors that occur before and during pregnancy and during early infancy via a stratified sample of women delivering a live birth. PRAMS data are used by BFH to develop strategies for improving maternal and birth outcomes.

The BFH through contracted referral relationships with treatment centers for metabolic and genetic abnormalities, families who have an infant with a presumptive positive test for an abnormality have access to comprehensive genetic services including an explanation of the disorder(s), education and examination of genetic history for families.

## **Perinatal/Infant Health**

Many of the services focused on perinatal/infant health are provided through collaborative work between the BFH and hospital facilities, using a combination of state and federal funds. BFH supports newborn screening tests by paying for the filter paper and laboratory analysis required for six mandatory infant screening tests and filter paper for the additional 22 recommended screenings. The BFH's Newborn Screening and Follow-up Program (NSFP) perform all testing follow-up for these screenings, hearing tests and screenings for Congenital Heart Disease and Severe Combined Immunodeficiency Disease. BFH staff are currently integrating processes with the labs to support new mandatory Lysosomal storage disorder screening. All infants with abnormal/inconclusive test results are referred to one of the BFH contracted treatment centers across the state for diagnostic evaluation and medical case management. The nursing services consultants from the BFH assist birthing facilities with quality assurance issues related to the NSFP such as state regulations and procedures and policies.

Two other BFH programs coordinate efforts through hospitals. The Shaken Baby Syndrome Prevention Program provides supplies, guidance and nursing in-service training to all birthing and children's hospitals in order to ensure that every parent or caregiver of a child born in PA receives shaken baby syndrome education. Keystone 10 is an initiative working with birthing facilities on the adoption and implementation of ten evidence-based steps to baby friendly facilities using education and regional learning collaboratives.

The BFH operates the Healthy Baby hotline as a mechanism for pregnant and new mothers to access information and resources on insurance coverage, obtaining prenatal care and referrals to local healthcare providers and breastfeeding professionals.

The BFH home visiting programs also provide education services on infant care and development once the baby is born. The Cribs for Kids program promotes safe sleep practices aimed at reducing the incidence of infant death due to SIDS and accidental suffocation and strangulation. The program fosters statewide collaboration by working with community partners in order to reach those most in need, and partnering with Graco to supply pack and plays and other infant safety products.

The BFH is part of the PA Perinatal Partnership a collaboration of the Healthy Start projects in PA as well as the local Title V agencies that is interested in working with the BFH to better understand how the Life Course model is being implemented throughout MCH programming.

### **Child Health**

The provision of child health programs by the BFH are more community based.

The BFH provides services for children in numerous programs across PA. In 2013, 5 percent of children were without health insurance coverage and 34 percent of children are covered by Medicaid or the Children's Health Insurance Program (CHIP). Title V nurses in the 10 local health departments staff clinics which are offered to children who have no insurance due to a gap in coverage between providers or insurances or for children who are uninsured or uninsurable. Assessments and basic health services such as growth and development, oral health, lead screenings and immunizations are offered as well as referrals for issues nursing staff is unable to treat. Title V nurses also staff dedicated immunization clinics in numerous locations throughout the state to ensure vaccinations are accessible for all families. These services are provided to offer a safety-net for the Title V population.

The PDPH offers a clinic specifically designed for youth aimed toward improving their health and knowledge about health related issues. Staff assesses psychosocial and reproductive needs and offers referrals to clinical, social and behavioral health services as well as engaging teens in reproductive life planning.

The Allentown City Bureau of Health, Montgomery County Health Department (MCHD) and Wilkes-Barre City Health Department provide dental services to children, through the age of 21, who are uninsured, underinsured or uninsurable. Essential services such as routine examinations, cleanings, extractions and fillings are combined with oral health care education. In 2014, 545 individuals received dental services through these programs. The BFH has supported local Title V agencies in providing dental services and increasing the number of children receiving these services.

The BFH administers the Public Health Child Death Review (CDR) Program, which requires 63 child death review teams covering 67 counties to discuss the circumstances surrounding the deaths of all children 21 years of age and under, and to make recommendations to the State CDR Team and the DOH to promote the safety and well-being of children and reduce child fatalities. The local teams are comprised of community professionals and conduct a multi-disciplinary review of a child's death with a focus on risk factors and prevention recommendations.

The BFH, through regional grantees, provides primary prevention of home-related injuries and illness to families across the state through a home visit with follow-up, education on healthy homes concepts and interventions to address potential hazards. These grantees also conduct inspections of homes where children with elevated blood lead levels reside in order to identify lead exposure sources. Education and technical assistance is provided to

clinicians and partners regarding healthy homes concepts.

The BFH oversees the Childhood Lead Surveillance Program, which monitors childhood lead testing and results through the Pennsylvania National Electronic Disease Surveillance System, a web-based application system that receives all lead reports submitted by laboratories. Surveillance data is used to identify possible high risk areas and other potential service gaps.

## **CSHCN**

Due to the broad range of care and coordination needed to meet the needs of the CSHCN population, the BFH supports a variety of direct, support and referral services across the state including those provided by the local health departments to support CSHCN in their communities.

The Title V Family Advisor is used as a liaison between families with CSHCN and the BFH to ensure appropriate representation in program planning and policy making in addition to facilitating a partnership with the Department of Human Services (DHS) to address systematic issues and coordination of care.

The Special Kids Network reaches statewide with in-home service coordination provided by community partners, eight regional coordinators trouble-shooting service challenges from their experience as parents of CSHCN and a toll-free helpline to link families with services.

The BFH provides comprehensive, multi-disciplinary health related services to individuals with certain conditions through the Comprehensive Specialty Care Program including care coordination and information and education provided by hospitals and community organizations.

The PA Medical Home Initiative (MHI) is comprised of 74 medical homes serving 505,555 children including 29,959 CSHCN in practices across the state. The MHI also currently uses 197 parents in the role of Parent Partner to assist practices in enhancing their service from the viewpoint of a parent.

The BFH partners with the DHS for Project LAUNCH, a federal grant that promotes the wellness of young children from birth to 8 years of age by addressing the physical, social, emotional, cognitive and behavioral aspects of their development.

BrainSTEPS is a Child and Adolescent Brain Injury School Re-Entry Program which ensures that those who provide educational support to children with acquired brain injuries understand brain injury and the resulting challenges.

The BFH's memorandum of understanding with the Department of Aging (PDA) allows the BFH to use PDA's Pharmaceutical Assistance Contracts for the Elderly program's claims processing and administrative functions to provide metabolic formula for CSHCNs, including Spina Bifida, Cystic fibrosis and PKU. The MOU allows the BFH to expand the number of accessible pharmacies and consolidate claims processing through a single administrative agency.

The BFH partners with the PA Chapter of the American Academy of Pediatrics and Tuscarora Intermediate Unit to provide referral and follow-up services to infants who fail a hearing screening. BFH staff works with these partners to educate clinicians and parents on the importance of screening and early intervention for better hearing outcomes.

## **Adolescent Health**

The BFH's Adolescent Health programs include the Personal Responsibility Education Program (PREP), Teen

Pregnancy Prevention, Reproductive Health Services, Healthy Youth PA and the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth Program.

PREP supports programs to delay sexual activity, increase condom or contraceptive use and reduce pregnancy.

Health Resource Centers operate in Philadelphia and Bucks county schools as part of Teen Pregnancy Prevention. The BFH is currently working with AccessMatters to expand to high risk areas across the state. Adagio Health operates three teen pregnancy prevention programs in twelve counties.

The LGBTQ Youth Program provides services to LGBTQ youth to include suicide prevention training and engages in coalition building activities with ally organizations to help them become Safe Space certified. The program also provides a drop-in health center for youth to obtain health care and social services. Training is provided to medical, behavioral health and social service providers on a variety of topics including health disparities, appropriate standards of care for LGBTQ individuals and LGBTQ cultural competency.

Healthy Youth PA is targeted to counties with the highest rate of teenage pregnancy for youth under the age of 15 and youth ages 15 to 17 and incorporates a combination of mentoring and adult-led group discussions for youth ages 9-14 as a means of promoting abstinence from sexual activity. A parenting education component is included for parents or caregivers of the youth participants.

The BFH provides Reproductive Health Services including pregnancy testing, contraceptives, cervical cancer exams, screening and treatment for sexually transmitted diseases, education and counseling, and general health screening services.

### **Life Course**

Epidemiologic studies have effectively identified causal links between diseases and risk factors. However, a more subtle, nuanced approach involves understanding the link between social factors and health outcomes. Understanding this nuance is vital for Title V programs given the social risk factors inherent in the population served. These social risk factors include race, gender and socioeconomic status as well as the risk factors associated with stressful life events such as loss of employment, crime victimization or incarceration of a family member, friend or partner. Understanding and implementing the life course perspective means accounting for the risk and protective factors of populations served by Title V. Over time, these risk factors result in the weathering of certain populations; a physiological consequence of repeated and chronic stress which ultimately may impact the health and health outcomes of an individual. The life course perspective means understanding the need to increase protective factors throughout the life span for at-risk populations in order to make a positive impact on their health.

The BFH has engaged in training its own Title V and non-Title V staff about the impact of stressors, allostatic load and the research behind this model of understanding differences in maternal and infant mortality. The BFH used the HRSA and CityMatch toolbox to strengthen understanding.

The PDPH conducted a Life Course Perspective training program to increase knowledge of the life course perspective, improve understanding of racial, ethnic and socioeconomic-based health disparities and to enable participants to implement life course perspective in their respective field.

### **II.B.2.b.iii. MCH Workforce Development and Capacity**

The Bureau of Family Health (BFH) in conjunction with local Title V staff has a robust MCH/CSHCN as detailed in the

chart below.

PA Department of Health Title V Funded Staff Positions		
Program	Number of Funded Positions	Location
Bureau of Family Health Bureau Office	2	Harrisburg, PA
Bureau of Family Health Bureau Operations	3	Harrisburg, PA
Bureau of Family Health Child and Adult Health Services	16 (+2 non TV staff)	Harrisburg, PA
Bureau of Family Health Community Systems Development and Outreach	14	Harrisburg, PA
Bureau of Family Health Newborn Screening and Genetics	13	Harrisburg, PA
Bureau of Community Health Systems School Health	2	Harrisburg, PA
Bureau of Laboratories	1	Lionville, PA
Bureau of Informatics and Information Technology	1	Harrisburg, PA
Office of Legal Council	1	Harrisburg, PA
Policy Office	1	Harrisburg, PA
Office of Physician General	1	Harrisburg, PA
Local Title V staff – MCH	91	Statewide
Local Title V staff – CSHCN	42	Statewide
Total	188	

The BFH has two staff members and nine contracted staff members who are parents of CSCHN. There are 10 MCH consumers and 40 family members of MCH consumers are volunteers on advisory boards that represent the diverse MCH population.

Most staff previously worked outside the BFH in various fields and organizations with ties to the Pennsylvania (PA) MCH population. This diversity of experience combined with pre-established program relationships both within and outside the Department of Health (DOH) provides invaluable knowledge to help further Title V endeavors. The recently appointed Physician General Dr. Rachel Levine will be a valuable advocate for MCH programs at the executive level due to her experience and specialization in child and adolescent health, including the complex care of teens with medical and psychological problems, eating disorders and transgender medicine.

The vacancy in the State Public Health Dentist position, while not directly impacting the BFH, represents a void of expertise regarding oral health within the DOH. BFH has experienced management staff, but lacks incentives for staff growth, thus leading to areas of high turnover. This has been an issue with the MCH coordinator position, which is currently filled but has historically been difficult to retain. BFH Title V staff and their contractors continually seek additional training on the MCH populations served in PA as well as evolving national trends and initiatives.

The BFH's Director, Division Directors and Title V Block Grant Coordinator serve as the lead MCH-related positions that contribute to planning, evaluation and data analysis capabilities. Below are the names and qualifications of the current staff. The Division Directors have over 50 years of collective MCH experience. Many of the BFH's Program

Managers, also considered senior staff, have served in their positions between 5 and 10 years.

Director of the Division of Child and Adult Health Services: Carolyn S. Cass

Ms. Cass has worked in the field of Public Health since 1997. Before joining the BFH she worked in the field of behavioral health for over 15 years, primarily providing drug and alcohol treatment services for adolescents and adults in the state hospital system. Since 1994 Ms. Cass has served as adjunct faculty at West Chester University and has served on the faculty at Temple University as well. Ms. Cass has a Master's Degree in Sociology and a PhD in Criminal Justice.

Ms. Cass has served as the Acting Director for the BFH effective February 2015.

Director of the Division of Community Systems Development and Outreach: Michelle Connors

Ms. Connors has served in the field of Public Health for over 20 years. She came to the DOH in 1989 and has served as the state's Title V Children with Special Health Care Needs Director since 2002. Ms. Connors holds a Bachelor's Degree from Pennsylvania State University. Her division manages a variety of programs that focus on children with disabilities.

Title V Block Grant Coordinator: Sara Thuma, MPH

Ms. Thuma holds a Master's of Public Health from Johns Hopkins University and a Bachelor's Degree from the University of Colorado. Ms. Thuma came to the DOH this year and is tasked with spearheading efforts for planning, evaluation and data analysis within the BFH. In collaboration with program staff Ms. Thuma works to collect, analyze and interpret data to make recommendations that will enhance program delivery to the MCH population.

Acting Director of the Division of Newborn Screening and Genetics: Kelly Holland

Ms. Holland has served in the field of Public Health for over 10 years. She came to the DOH in 2005 and has held several roles related to maternal and child health including: genetics program administrator, state adolescent health coordinator/adolescent health program administrator and public health program manager. Ms. Holland holds a Bachelor's Degree from the University of Pittsburgh.

The DOH is committed to ensuring that services provided directly and through contracts and grants are performed in a culturally competent manner from the planning stages to final implementation.

The DOH's Bureau of Health Statistics and Research collects and analyzes a wide array of primary and secondary data that is used by the BFH to inform program development and service delivery. Data are collected and analyzed to take into account cultural groups and other disparity factors. Primary data collected by the DOH includes the Pregnancy Risk Assessment Monitoring System (PRAMS), birth certificates, death certificates, PA Immunization Information System (PA-SIIS) and PA's National Electronic Disease Surveillance System (PA NEDSS). The BFH also uses data from the National Child Death Review Case Reporting System, US Census and American Community Survey, National Center for Health Statistics and Healthy People.

The DOH ensures ongoing training for staff, family leaders, volunteers, contractors and subcontractors in the area of cultural and linguistic competence. The following examples are some of the ways in which the DOH provides this training.

The DOH's Office of Health Equity (OHE) hosted a Health Equity Conference in August 2014. More than 300 health professionals, community leaders and stakeholders attended to discuss ways to address health disparities and the effect of chronic diseases in Pennsylvania. Means to improve these conditions included health literacy approaches that can help to reduce health disparities, the role of culturally and linguistically appropriate services standards,

cultural competence of clinicians and the impact on limited English proficient patients and mental and behavioral health.

The DOH's Cultural Competence Taskforce is comprised of employees who represent the diverse populations of PA and develop training courses related to cultural competence, cultural sensitivity, National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS), health literacy, diversity, poverty and other social determinants of health faced by populations served by the DOH. These face to face and online courses will be offered to employees highlighting how the healthcare workforce can communicate effectively with diverse populations.

The DOH partnered with the National Center for Cultural Competence (NCCC) to provide professional development for PA stakeholders on cultural and linguistic competence and their importance in serving CSHCN.

The DOH collaborates with community leaders/groups and families of culturally diverse groups in needs/assets assessments, program planning, service delivery and evaluation/monitoring/quality improvement activities as part of our standard business practices.

The OHE has an advisory committee with representatives of various stakeholder organizations that developed a tactical plan outlining a five-year strategic direction that will be implemented through an organized and collaborative effort of OHE and its partners, including public, private and nonprofit stakeholder organizations.

In December 2014, the DOH endorsed and adopted the CLAS standards. The DOH expects all staff, grantees, stakeholders, contractors or service providers, outreach initiatives, health services and health care practices to adhere to and follow these principles and standards in the pursuit of advancing health equity, improving quality and helping to eliminate health care disparities in PA. The adoption of CLAS means that all members of an organization, regardless of size, are encouraged to apply them at every point of contact.

The Commonwealth and the DOH have policies and procedures to ensure that employees conduct and behavior creates an environment of inclusion, free from discrimination. The Standard General Terms and Conditions of DOH contracts and grants include a provision that all services available to the public shall not be denied or restricted due to race, creed, color, religion, sex, sexual preference, age, handicap or national origin including limited English proficiency.

### II.B.2.c. Partnerships, Collaboration, and Coordination

The Bureau of Family Health (BFH) is one of many agencies and organizations that serve the MCH population in Pennsylvania (PA). It is through partnerships, collaboration, and coordination with other agencies and organizations that the BFH has been able to not only measure improvements in the health and well-being of PA's mothers, infants, children and youth, including CSHCN and their families, but examine the reach and effectiveness of its programming for the MCH population. The chart below details these important BFH relationships.

Other MCHB investments	
State Systems	BFH administers the HRSA grant that will be used to build and expand state MCH data capacity to support Title V program efforts. This will expand data-driven decision-making in MCH programs by strategically

State systems Development Initiative (SSDI)	expand data driven decision making in MICH programs by strategically managing and integrating existing health information systems. Data will include sources from DOH as well as stakeholders and partners.
Other Federal investments	
CDC 1305 Grant: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors, and Promote School Health	Through collaboration with the DOH's Bureau of Health Promotion and Risk Reduction, who was awarded this grant, the BFH is pursuing the establishment of breastfeeding friendly employers.
Child Death Review Teams (CDR)	DOH is responsible for administering the Child Death Review (CDR) Program and works closely with the Department of Human Services and the Pennsylvania Chapter of the American Academy of Pediatrics. The goal of CDR is to reduce the incidence of preventable child deaths by combining multi-agency and multi-disciplinary reviews of these deaths with the implementation of targeted prevention efforts aimed at Pennsylvania's most vulnerable populations.
School Re-Entry Program	BFH represents DOH not only as a founding partner, but current leading partner for the BrainSTEPS (Strategies Teaching Educators, Parents and Students) Program. BrainSTEPS works to ensure that those who provide educational support to children with brain injury have an understanding of brain injury, its resulting challenges, and the supports and interventions that will help these students achieve optimal educational success through graduation.
Shaken Baby Syndrome	DOH collaborates with Penn State Hershey Medical Center and Dr. Mark Dias, a nationally recognized expert in the field of Shaken Baby Syndrome (SBS) to provide information and education to parents aimed at

<p>Shaken Baby Syndrome Program (SBS)</p>	<p>(SBS), to provide information and education to parents aimed at preventing abusive head trauma to a child after birth. All birthing hospitals in Pennsylvania participate in this important program providing parents with alternative behavioral responses to infant crying.</p>
<p>Cribs for Kids</p>	<p>DOH partners and provides funding for this safe-sleep education program for low-income families aimed at reducing the risk of injury and death of infants due to unsafe sleep environments.</p>
<p>Personal Responsibility Education Program (PREP)</p>	<p>DOH administers PREP, which provides evidence-based teen pregnancy prevention programs, education on healthy relationships, adolescent development, and healthy life skills. DOH partners with Persad Center, Inc. to provide lesbian, gay, bi-sexual, transgender and questioning (LGTBQ) cultural competency services to PREP implementation sites. Services include an assessment of organizational LGBTQ cultural competency, LGBTQ 101 and advanced trainings for staff as well as ongoing technical assistance.</p>
<p>The Pennsylvania Pregnancy Risk Assessment Monitoring System (PA PRAMS)</p>	<p>PA PRAMS is a research and surveillance system that serves the maternal and infant community. It is managed within the BFH. It produces a rich dataset of maternal behaviors and experiences captured through a survey process. Data is analyzed and shared in an effort to inform programs both within the DOH and with outside partners and stakeholders.</p>
<p>Lead Hazard Control Program (LHCP)</p>	<p>DOH administers the LHCP in targeted areas of Pennsylvania and partners with other LHCPs in Pennsylvania to create lead-safe home environments for low-income families with children under age 6.</p>
	<p>BFH partners with WIC to jointly develop breastfeeding education materials and to ensure that community based breastfeeding initiatives</p>

WIC	involve collaboration with local WIC agencies and populations. Additionally, electronic records are routinely shared between the PA PRAMS program and WIC in an effort to identify telephone numbers for sampled and surveyed mothers. This collaborative relationship serves to elevate the PA PRAMS survey response rate. Lastly, BFH partners with WIC to ensure PKU formula is provided for CSHCN through five years of age.
Other HRSA programs	
Federally Qualified Health Centers	The PA Medical Home Program, administered by BFH, collaborates with FQHCs as a means to reach CSHCN in underserved areas.
Newborn Hearing Screening Program	DOH, through the BFH, provides universal newborn hearing screening and intervention through a HRSA grant. In July 2011, the Hands and Voices Guide by Your Side (GBYS) of PA program was launched in all areas of the state to provide parent guides to families. These guides have experience in a variety of communication options and knowledge of diverse hearing loss through diagnoses of their own children. Matches between parent guides and families have been based not only upon geographic proximity, but also upon similarity of diagnoses, hearing levels, communications strategies and technology choices such as cochlear implants or hearing aids. The provision of direct referrals to GBYS became a more formalized and consistent process in January 2014, and this has resulted in services being provided to families with children with hearing loss at a much younger age.
Traumatic Brain Injury Implementation grant	DOH is the lead agency in a number of initiatives aimed at increasing awareness regarding brain injury. These activities consist of training to increase awareness of and screening for TBI in athletes of all ages including youth in intramural athletics which are not affiliated with a school district; screening youth in juvenile justice facilities in order to

	identify individuals with TBI and assure the provision of appropriate services; technical assistance to juvenile justice facilities and youth athletic associations; and issuance of Continuing Medical Education credits to physicians completing concussion training.
State and Local MCH programs	
Philadelphia Special Needs Consortium (PSNC)	The BFH partners with the PSNC, operated through the Philadelphia Public Health Department, to provide programs and resources for CYSHCN and their families.
County Municipal Health Departments	The Department provides funding to the ten county municipal health departments to deliver health services to low income Pennsylvania citizens. The county municipal health departments work to offer health services to women, infants and children who are underinsured, uninsured or uninsurable. The maternal and child health nursing staff assist the newborn screening program by providing filter papers and lancets to those in need in emergency situations. Clients are also provided with referral information to newborn screening metabolic treatment centers.
Other programs within the State Department of Health	
Bureau of Public Health Preparedness (BPHP)	The BFH Family Advisor collaborates with the BPHP on emergency preparedness planning for CSHCN.
Office of Health Equity (OHE)	The BFH collaborates with OHE on initiatives related to ensuring that cultural and linguistic competence standards are met across the DOH and within BFH programming.
Division of Obesity, Physical Activity and	The BFH partners with the Division of Obesity, Physical Activity and Nutrition to provide information and assistance regarding breastfeeding

Nutrition	across Pennsylvania.
Violence and Injury Prevention Program (IVPN)	DOH administers the Violence and Injury Prevention Program and oversees the Injury and Violence Prevention Network (IVPN). The BFH provides funding and collaborates with the IVPN endeavors to develop a comprehensive and coordinated injury prevention effort.

The Pennsylvania Dept. of Health's Bureau of Health Statistics and Research (BHSR), Division of Vital Statistics	An ongoing collaboration between the CDR program and BHSR facilitates the generation and sharing of birth and death records. These records are shared with local review teams and serve as the primary reports to determine which reviews are initiated.
Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS)	PA-NEDSS is a statewide, web-based surveillance system that receives and stores reports for all diseases reportable to the Department of Health. Data stored within PA-NEDSS can be used to identify high-risk areas, analyze service gaps, and inform programmatic decisions. The ongoing maintenance of PA-NEDSS is a collaborative effort between DOH's Bureau of Informatics and Information Technology (BIIT) and a number of programs within DOH including those in the BFH.
Environmental Public Health Tracking Network (EPHTN)	The Pennsylvania EPHTN is an effort to collect, analyze, document, and provide information on suspected links between environmental hazards and their impact on the health of citizens. BFH regularly participates in planning and development efforts and annually delivers a childhood lead dataset for inclusion in the EPHTN database and website.
	The BFH collaborated with the district community health nurses to assist the newborn screening program in the following ways: to obtain an initial or repeat filter paper, assist with PKU monitors, educate, support and

Bureau of Community Health Systems (BCHS)	<p>or repeat filter paper, assist with TPO members, educate, support and make referrals to newborn screening metabolic treatment centers as needed.</p>
Bureau of Laboratories (BOL)	<p>BFH provides funding for a chemist at BOL who collaborates with the newborn screening program in the following ways: attends site visits to contracted laboratories; reviews all laboratory processes related to filter papers, provides technical expertise when adding new conditions to the screening panel, provides expertise in regard to the Clinical Laboratory Improvement Amendments (CLIA) and assists the program with the technical portion of program evaluation.</p>
Other governmental agencies	
Department of Education (PDE)	<p>PDE is an important partner with the BFH for programs for CSHCN. They are a resource and referral source for families with concerns related to Individual Education Plans (IEPs) and 504 Plans. In addition, BFH works closely with the Pennsylvania Training and Technical Assistance Network (PaTTAN) operated through the Department of Education. PaTTAN coordinates the Transition State Leadership Team, as well as the Rehabilitation for Empowerment, Natural Supports, Education, and Work (RENEW) groups on the topic of transition of YSHCN to adulthood. Additionally, BFH partners with PDE to develop school age TBI services such as the School Re-Entry program.</p>
Department of Labor & Industry	<p>The BFH works with the Office of Vocational Rehabilitation (OVR) through Labor and Industry on the transition of CSHCN to adulthood.</p>
	<p>The BFH partners and collaborates with several different offices of DHS to meet the needs of families of CSHCN, including the Office of Medical</p>

<p>Department of Human Services (DHS)</p>	<p>meet the needs of families of children, including the Office of Medical Assistance Programs (OMAP), Office of Mental Health and Substance Abuse Services (OMHSAS), the Medical Assistance Transportation Program (MATP), and the Office of Child Development and Early Learning (OCDEL), which is an office operated jointly by the Departments of Education and Human Services. Additionally, callers to the Healthy Baby Helpline are often referred to the online COMPASS program where individuals can apply for medical assistance and other benefits. Further, the BFH collaborates with DHS on a childhood lead data match project. On a quarterly basis, claims data for Medical Assistance (MA) children are matched against BFH data on children who were tested for lead poisoning. Additionally, MA pays for newborn screening costs associated with the filter paper blood specimen and PKU monitoring.</p>
<p>Department of Drug and Alcohol Programs</p>	<p>BFH staff partner with the Department of Drug and Alcohol programs to identify cases and educate on Fetal Alcohol Spectrum Disorder (FASD).</p>
<p>The Pennsylvania Department of Transportation (PENNDOT)</p>	<p>A collaborative relationship between the DOH's Child Death Review (CDR) Program and PENNDOT serves to enhance child death review capacity. In securing traffic death information, the CDR program is able to provide local teams with critical information surrounding traffic fatalities.</p>
<p>Healthy Homes and Lead Partnership (HHLP)</p>	<p>BFH supports and convenes the HHLP, a partnership of health and housing advocates from across Pennsylvania that meet regularly to address lead poisoning prevention, healthy home environments, and related concerns.</p>
<p>PA Early Childhood Education Healthy &amp; Green Initiative</p>	<p>BFH partners with PDE, Department of Environmental Protection, and others to impact the environmental health of preschools, day care centers, and day care homes, so that vulnerable children are not exposed to health and safety hazards.</p>
<p>Public health and health</p>	

professional education programs and universities	
Albert Einstein Healthcare Network (AEHN)	The BFH collaborates with AEHN to provide a centering pregnancy program (group prenatal care) to Philadelphia women.
Lancaster General Hospital (LGH)	The BFH collaborates with LGH to provide a centering pregnancy program (group prenatal care) to Lancaster City women.
The Bloustein Center for Survey Research (BCSR) at Rutgers University	BFH collaborates with the BCSR to administer Pennsylvania's Pregnancy Risk Assessment Monitoring System (PRAMS) survey operations.
Temple University	The BFH's programs for CSHCN partner with Temple University's Institute on Disabilities on the TakeFIVE Respite Care Program which provides respite services for caregivers and siblings of CSHCN.
Comprehensive Specialty Care Program	BFH administers a number of grants providing services to individuals with a variety of conditions (sickle cell, hemophilia, ventilator dependent, cystic fibrosis, spina bifida and orthopedic and neuromuscular conditions). There is a large amount of state funds incorporated in these programs; however, the BFH ensures that the grantees conduct their activities in line with the tenets of the federal MCH funded programs. Partnerships between these state funded programs and MCH funded programs continue to be strengthened via information sharing and inclusion in planning and program activities.
	Temple University Harrisburg is the backbone organization for the PA Partnership for Healthy Youth: A Collaborative on Adolescent Sexual Health. The mission of the collaborative is to improve the health of Pennsylvania's youth by increasing the coordination and quality of initiatives that impact adolescent sexual health. Collaborative members

Temple University Harrisburg Campus	include staff from: several program areas in the Department of Health (including the BFH), the Department of Education, the Department of Human Services, the family planning councils in the Commonwealth, Planned Parenthood, Penn State University, school districts, LGBT centers, and adolescent medicine practitioners.
Family/consumer partnerships and	

leadership programs	
Traumatic Brain Injury Advisory Board (TBI)	The BFH supports the TBI Advisory Board which is comprised of an ethnically and culturally diverse group of individuals who have a commitment to serving those with brain injuries. Advisory Board members include individuals living with TBI, family members of individuals with TBI, representatives from a number of government agencies, and community-based organizations in TBI service provision and advocacy.
The Pennsylvania Perinatal Partnership (PPP)	The Pennsylvania Perinatal Partnership represents the collaborative efforts of Pennsylvania’s Healthy Start Projects and Maternal and Child Health Programs. There is an ongoing collaboration between PA PRAMS, administered by the BFH, and the Pennsylvania Perinatal Partnership (PPP).
Renal Disease Advisory Committee (RDAC)	The BFH supports the RDAC which is comprised of eleven members representing various interest groups including hospitals and medical schools which establish dialysis centers, volunteer agencies interested in kidney disease, local public health agencies, physicians/medical personnel interested in kidney disease, and the general public.
Newborn Screening Technical Advisory Board/Newborn Hearing Screening Technical Advisory Committee	The BFH supports both the Technical Advisory Board and the Technical Advisory Committee to provide expertise, medical advice on medications, and guidance on program improvement. The Board deals with issues related to the metabolic portion of the Newborn Screening Program and the Committee deals with issues related to the hearing portion of the program.

The BFH considers family and consumer partnerships (FCP) a central tenet of serving the MCH population and employs a full-time Family Advisor who conveys the family perspective for program and priority planning. The PA Medical Home Initiative (MHI) utilizes 260 families and consumers as Parent Partners, Parent Advisors, Education Specialists, a Social Media Intern and a member on the Advisory Committee. The Special Kids Network (SKN) employs eight parents of CSHCN as Regional Coordinators and one Regional Coordinator Supervisor. BFH initiatives on Cultural and Linguistic Competence, Core Leadership and Project LAUNCH include 29 individuals from FCP. The Epilepsy Foundations and Tourette Syndrome grantees are operated by parents.

FCP are made up of a diverse group of members with various types of disabilities, racial and ethnic backgrounds and geographical areas. FCP engagement ranges from full-time employment to volunteers on workgroups. FCP who are not employed by the state or grantee are reimbursed for travel and childcare costs and all receive training on Title V. For example, the TBI Advisory Board includes a requirement that at least one-third of all board members must be an individual with a brain injury or a family member. Although positions on the board are not compensated, the BFH provides for transportation, lodging and subsistence. Additionally the TBI Advisory Board participated in focus groups to assist in the selection of block grant priorities.

Issues of importance to families and consumers are conveyed to the BFH through many mechanisms. In 2014, the SKN facilitated 148 family gatherings, meetings, and Parent Youth Professional Forums. Elks nurses provided 4,228 in-home service coordination visits. The MHI conducts semi-annual Parent Panels.

Title V funds and other resources have been combined to expand FCP involvement resulting in growth in the number and strength of BFH relationships with other programs and organizations.



## II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	MCH populations reside in a safe and healthy living environment.	Replaced	
2	Appropriate health and health related services, screenings and information are available to the MCH populations.	Replaced	
3	MCH populations are able to obtain, process and understand basic health information needed to make health decisions.	New	
4	Protective factors are established for adolescents and young adults prior to and during critical life stages.	Replaced	
5	Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants.	New	
6	Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.	Replaced	
7	Safe sleep practices are consistently implemented for all infants.	New	
8	Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.	New	This priority will supplement the capacity to achieve all other priorities using data driven decisions to support evidence based measures.
9	Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.	Replaced	

**Priority: MCH populations reside in a safe and healthy living environment.**

A safe and healthy living environment encompasses the physical structure of the house as well as the behavioral and emotional factors within a home or neighborhood. Families and communities with financial insecurity or instability across the United States suffer disproportionately from the negative health effects of poorly constructed, unsafe and substandard housing. A number of research studies have documented these negative effects, which include asthma and other respiratory illnesses, cardiovascular health problems, increased stress, and adverse overall physical and mental health status. Additionally, social or behavioral factors within families such as domestic violence, familial substance abuse, or housing insecurity all have potential health implications.

This priority replaces the prior state priority to expand injury prevention activities for infants, children and adolescents. The replacement priority more broadly addresses the entire MCH population while more narrowly focusing on the living environment which the Bureau of Family Health (BFH) is able to affect with Title V resources.

**Priority: Appropriate health and health related services, screening and information are available to the MCH populations.**

Access to health and health related services is crucial to securing necessary screening, care and treatment. If the services that are received are not appropriate, at best they are ineffective and at worst they cause injury and death. Due to varying needs such as medical complexity and language or cognitive limitations the MCH population requires providers to address them as individuals and tailor services, screenings and information to suit the individual consumer. Appropriate services also include timely diagnosis and follow-up.

This priority replaces the prior state priority to increase awareness of and access to comprehensive information about services and programs for CSHCN. The replacement priority more broadly focuses on the entire MCH population and that the services, screening and information are appropriate for the individual and their needs.

**Priority: MCH populations are able to obtain, process and understand basic health information needed to make health decisions.**

Health literacy is the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions. Nearly 9 out of 10 adults have difficulty using the everyday health information that is routinely available in health care facilities, retail outlets, media and communities. Limited health literacy is associated with poorer health outcomes and higher health care costs. Improving health communication and utilizing health technologies are essential to promoting individual and population health.

This priority is new and was strongly influenced by feedback from stakeholders that information is not making its way into the hands of the MCH population and when it reaches them, it is not presented in a manner that is understandable or useful. Health literacy impacts all of the population health domains and is important in the types of service delivery as well.

**Priority: Protective factors are established for adolescents and young adults prior to and during critical life stages.**

Efforts to improve child and adolescent health have typically addressed specific health risk behaviors, such as early initiation of sexual intercourse, tobacco use or violence. However, results from a growing number of studies suggest that greater health impact might be achieved by also enhancing protective factors that help children and adolescents

develop the life skills and assets they need to avoid multiple behaviors that place them at risk for adverse health and educational outcomes.

Protective factors are individual or environmental characteristics, conditions or behaviors that reduce the effects of stressful life events. These factors also increase an individual's ability to avoid risks or hazards and promote social and emotional competence to thrive in all aspects of life, now and in the future. During the needs assessment process, stakeholders reported to the BFH that many adolescents and children do not have a strong foundation of parental or adult support to help them succeed in school, health and social circumstances, which leads to long-term difficulty. An increase of protective factors during adolescence is especially important for some vulnerable populations, such as lesbian, gay, bisexual, transgender and questioning (LGBTQ) adolescents.

This priority replaces the prior state priorities to decrease teen pregnancy through comprehensive sex education and to expand access to physical and behavioral health services for high risk youth such as LGBTQ runaway/homeless by expanding the focus to all adolescents and protective factors at large. Statewide teen pregnancy rates have improved so that a narrow focus is no longer needed. The expanded focus of the priority will allow the BFH to provide programming that meets the needs of specific subpopulations of adolescents to mitigate life stressors for improved outcomes as adults and in future generations.

**Priority: Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants.**

Protecting, promoting and supporting breastfeeding, with its many known benefits for infants, children and mothers, are key strategies to accomplish improving the health of mothers and their children. The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for the first six months, continued breastfeeding for the first year and then for as long as mutually desired by mother and child. For mothers to have success with breastfeeding they require the support of their family. In 2014, Pennsylvania continued to fall below the national breastfeeding rates for ever breastfed, breastfeeding at six months, breastfeeding at 12 months, exclusive breastfeeding at three months and exclusive breastfeeding at six months.

This priority is new and was a clear choice based upon the current breastfeeding rates and feedback from stakeholders. The BFH has a unique position to support families and systems to improve the initiation and continuation of breastfeeding. The BFH will seek to implement initiatives that not only focus on the mother and healthcare provider, but also include the father or partner and extended family to address barriers that may traditionally prevent a mother from initiating or continuing breastfeeding.

**Priority: Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.**

Maternal behaviors known to be related to poor birth outcomes include tobacco use, alcohol use and failure to consume adequate folic acid through multivitamins or diet. Evidence suggests that successful interventions targeting these behaviors prior to pregnancy are associated with improved health of the woman and her infant. Other conditions associated with poor pregnancy outcomes include having an unintended pregnancy, experiencing physical abuse and experiencing high levels of stress. Certain maternal health conditions (e.g., diabetes, hypertension and obesity), if uncontrolled, can lead to poor infant outcomes and have a long-term negative impact on a woman's health. Because a woman might have a subsequent pregnancy, services in the postpartum period (e.g., a postpartum check-up, screening for postpartum depression, counseling about birth control and accessing services such as WIC) are all opportunities to help women maintain or regain good health.

This priority replaces the prior state priority to decrease barriers for prenatal care for at-risk/uninsured women through implementation of best practices. By shifting the focus of the priority to preconception and inter-conception care and support, the BFH will be able to provide preventive care and support to address behaviors and risk factors before they have a negative effect on the mothers and infants.

**Priority: Safe sleep practices are consistently implemented for all infants.**

It is commonly recognized that babies not placed on their backs to sleep are at greater risk for SIDS. According to the AAP Task force on Infant Sleep Position and Sudden Infant Death Syndrome, belly-sleep has up to 12.9 times the risk of death as back-sleep. Despite a nationwide reduction in the incidence of SIDS since 1992 when the AAP issued recommendations regarding back to sleep, the decline has plateaued in recent years. Furthermore, according to the AAP, concurrently, other causes of SUID that occur during sleep (including suffocation, asphyxia and entrapment) and ill-defined or unspecified causes of death have increased in incidence. Consequently, in 2011, the AAP expanded the recommendations from focusing only on back-sleeping to focusing on a safe sleep environment to reduce the risk of sleep-related infant death. A cornerstone of the AAP expanded recommendations is room-sharing without bed-sharing, which evidence shows decreases the risk of SIDS by as much as 50 percent.

In 2013, the Department of Health (DOH) issued a policy statement on safe sleep that is closely aligned with the recommendations made by AAP. This policy statement provides the weight of DOH support for encouraging practices that reduce the risk of death due to SIDS and unsafe sleep practices and represents the first time the DOH has taken a formal position on safe sleep.

This priority is new; however, was part of prior state priority to expand injury prevention activities for infants, children and adolescents. As a new and standalone priority, safe sleep for infants will be able to receive the focus and resources needed to effect safe sleep practices for all infants.

**Priority: Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.**

All BFH programs collect data on program activities and participants; however, all of the sources of data have not been used to the full capacity to effectively inform decision-making and evaluate population and programmatic needs. The increasing demands to provide results by using evidence-based and informed practices have allowed the BFH to see missed opportunities in current practices and the potential to improve practices around the identification, collection and use of data. Many stakeholders and partner agencies expressed that as there are insufficient resources to address all of the population needs, there is an increasing need for using data to target resources.

This priority is new and will ensure steps are taken to improve capabilities within the BFH. By focusing on data for this grant cycle, the BFH will make changes in procedures and processes to institutionalize best practices for a successful future.

**Priority: Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.**

Women's health and the health and wellbeing of their children can be affected by many life stressors including emotional issues, alcohol, tobacco, other drug use and intimate partner violence. Without mitigation, these stressors

continue across the life span leading to generational transmission during critical periods. In Pennsylvania there is a significant problem with opioid abuse, addiction, prescription drug abuse and neonatal abstinence syndrome. While screening alone will not ameliorate the complex problem of opioid and other drug addiction it will provide the opportunity for women to be referred for assistance and treatment to establish healthy life goals and potentially decrease the harmful effects of these stressors on their children.

This priority replaces the prior state priority to increase behavioral health screening, diagnosis and treatment for pregnant women and mothers (including postpartum depression). The replacement priority continues to address behavioral health with a more narrow focus on specific services that the BFH will be more directly able to affect with Title V resources.

When selecting priority needs the BFH considered several factors to determine the extent of the need and whether it was within the scope of the BFH's capacity to affect change. The main factors contributing to the selection of priorities included:

- the severity of the problem, specifically in relation to the severity nationally;
- the scope of the need as a statewide concern;
- alignment with the current vision and mission of the Department; and
- the ability of the BFH to impact the problem without duplicating existing efforts.

As a result of this review process, local or regional issues for which the BFH and Title V funds are not the best mechanism to impact change were not selected. Statewide issues were not selected if the BFH either does not have the capacity to address or the need is specifically addressed by another bureau within the DOH or other state agencies. Whenever possible, narrowly focused needs were included as part of a broader priority that included either multiple population domains or more than one specific need. The following topics were identified during the needs assessment but were not selected as priorities.

Oral health: Though this was a concern voiced by some stakeholders, the BFH determined that a designated priority for oral or dental health services was not warranted. Almost 80 percent of PA children have had a preventive dental visit in the past year (11-12) compared to 78 percent nationally. The DOH does not currently have a public health dentist to champion efforts of increasing availability of oral health services for children, but has provided funding for dental clinics via Primary Care grants.

Support services such as transportation, childcare, education and nutrition: BFH did not prioritize needs that would duplicate services with existing widespread infrastructure through other agencies. BFH addresses these issues within specific initiatives and programs, but the BFH does not have the appropriate capacity to address these as standalone priorities without duplicating services. The BFH will continue efforts to partner with the other agencies and bureaus to promote the needs of MCH populations and offer avenues to better reach and serve the MCH population.

Transition: BFH had a prior state priority to improve the transition of CYSHCN from child to adult health, educational and social services. BFH staff and stakeholders believe that transition is not exclusive to CSHCN and there are benefits to addressing transition for all adolescents. Increasing protective factors for adolescents is one way to begin to expand transition activities to all adolescents. Transition services may be considered as a future objective or strategy within the scope of the new priorities.

**II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures**

**NPM 1-Percent of women with a past year preventive medical visit**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	68.0	68.7	69.4	70.1	71.4

**NPM-4 A) Percent of infants who are ever breastfed**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	74.0	76.0	78.0	80.0	82.0

**NPM-4 B) Percent of infants breastfed exclusively through 6 months**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	17.0	18.0	20.0	23.0	26.0

**NPM 5-Percent of infants placed to sleep on their backs**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.2	79.0	79.8	80.6	82.1

**NPM 7-Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	188.7	186.8	184.9	183.1	179.3

Annual Objectives					
	2016	2017	2018	2019	2020

**NPM 9-Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14.5	14.3	14.1	13.9	13.7

**NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	86.9	87.8	88.7	89.6	91.2

**NPM 11-Percent of children with and without special health care needs having a medical home**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.0	50.5	51.0	51.5	52.5

**NPM-14 A) Percent of women who smoke during pregnancy**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14.0	13.7	13.2	13.0	12.8

**NPM-14 B) Percent of children who live in households where someone smokes**

Annual Objectives					
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	2016	2017	2018	2019	2020
Annual Objective	28.3	27.3	26.3	25.3	24.3

Based on the priority needs selected by the BFH for the five-year reporting period, the following eight NPMs were selected to be addressed. MCH population needs and BFH capacity to impact the NPM were leading factors in the process to select the NPMs.

**NPM 1: Percent of women with a past year preventive medical visit**

Of the two NPMs specific to the women/maternal health domain, the BFH felt NPM 1 was most closely related to its chosen priority focusing on access and participation in preconception and interconception care. The BFH envisions a shift to more holistic care for women through the childbearing years, not just during pregnancy. Moreover, when considering the aspects of the BFH's capacity, it was determined the BFH had a much higher likelihood of impacting this NPM based on existing infrastructure and capacity to implement pertinent strategies.

**NPM 4: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months**

While the PA breastfeeding rate is increasing, PA still lags far behind many other states and the nation in the percent of infants who are ever breastfed. There are also tremendous disparities in rates of breastfeeding between counties and racial and ethnic groups within the state. The BFH has chosen to make breastfeeding a priority in order to address not only breastfeeding across the state, but also target programming to areas with the greatest disparities. Moreover, through the information collected by the Bureau of Health Statistics and Research (BHSR), PA PRAMS and other national breastfeeding tracking systems, the BFH has a fairly large capacity to track breastfeeding behaviors and refine programming to address the issue within the state. The selection of NPM 4 is then a logical choice.

**NPM 5: Percent of infants placed to sleep on their backs**

With safe sleep practices being chosen as a priority for PA, NPM 5 is another logical choice for the BFH. PA has legislation requiring all parents receive safe sleep education before leaving the hospital. Sudden infant death syndrome (SIDS) is one of the top five causes of death for those under the age of one in PA. The American Academy of Pediatrics (AAP) has also issued a recommendation for safe sleep in 2011 and DOH issued a policy statement closely aligned with the AAP recommendations in 2013. BFH has vast data resources regarding specific safe sleep and related behaviors including information from BHSR, PA PRAMS and the Child Death Review (CDR) Program that can be leveraged for policy and program formation and expansion.

**NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19**

The BFH has chosen a priority focused on creating a safe and healthy living environment for the MCH population and selected NPM 7 for the child health domain. Despite the fact that the DOH has other sections working toward injury prevention, the BFH concluded this NPM, of the three related to the child domain, was where there was capacity to make the most impact by building on existing home visiting models and expanding emphasis on potential injury hazards in the home environment. Because of the effectiveness of the existing CDR Program, the BFH is also interested in using CDR data and recommendations to implement initiatives that closely reflect the needs of the child population.

**NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

**NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year**

The adolescent population is of particular importance to the BFH so both NPMs specific to this population were chosen as measures to align with two different priorities defined by the BFH. The NPM related to bullying is most closely related to the BFH priority surrounding the establishment of protective factors for adolescents and young adults during critical life stages. The NPM related to a preventive medical visit for adolescents is most closely aligned with the BFH priority focusing on preconception and interconception care. The BFH is particularly concerned with the lack of resources and protections for the LGBTQ youth community especially with regard to bullying and medical care and is looking to develop and expand programming and data capacity to support this underserved and marginalized community. Bullying of CSHCN will also be a focus for the BFH.

**NPM 11: Percent of children with and without special health care needs having a medical home**

The BFH has prioritized appropriate health and health related services for the MCH population and the NPM regarding medical home was determined to most closely fit with this priority. There is a large and growing need for the coordination of services within a medical home for all children, but especially for CSHCN. PA has a strong medical home program with 74 practices established and the BFH has chosen to expand on this pre-established capacity. An additional benefit is that medical homes are not limited to CSHCN or the MCH population so that all residents have the potential for improved health care delivery. The BFH also feels the NPM regarding transition is important and will seek to incorporate it during the grant cycle as a state performance measure.

**NPM 14: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

Of the three cross-cutting/life course NPMs, the BFH decided it had the capacity to make the greatest impact with NPM 14. The BFH can draw on information from PA PRAMS and BHSR and integrate smoking-cessation messages into other programming, especially home visiting models. The Pennsylvania Comprehensive Tobacco Prevention and Control Program is housed within another bureau of the DOH, but the BFH identified this NPM as a way to coordinate and align programming with the available services provided by the DOH. Moreover, this NPM most closely aligns with the BFH priorities regarding MCH populations residing in safe and healthy living environments and women being screened for behavioral health issues. As a cross-cutting topic, successfully impacting this NPM will provide for benefits to mothers regarding maternal morbidity; infants regarding low birth rates, preterm birth rates, mortality and SUIDs; and children regarding overall health.

## **II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures**

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.	<p>Annually increase the percent of adolescents/women who talked with a health care professional after delivery about birth spacing or birth control methods.</p> <p>Annually increase the percent of adolescents/women who are engaged in family planning after delivery.</p>	<p>Implement evidence based or informed home visiting services (ex. Nurse Family Partnership, Bright Futures, Partners for a Healthy Baby)</p> <p>Implement Centering Pregnancy Programs</p> <p>Implement innovative interconception care initiatives for women</p> <p>Utilize motivational interviewing techniques</p>	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>Maternal mortality rate per 100,000 live births</p> <p>Percent of low birth weight deliveries (&lt;2,500 grams)</p> <p>Percent of very low birth weight deliveries (&lt;1,500 grams)</p> <p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <p>Percent of preterm births (&lt;37 weeks)</p> <p>Percent of early preterm births (&lt;34 weeks)</p> <p>Percent of late preterm births</p>	Percent of women with a past year preventive medical visit		

**State Action Plan Table**

**Women/Maternal Health**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
			(34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			

**Women/Maternal Health**

**Women/Maternal Health - Plan for the Application Year**

**Domain: Women/Maternal Health**

**Priority: Adolescents and women of child-bearing age have access to and participate in preconception and interconception health care and support.**

**NPM 1: Percent of women with a past year preventive medical visit.**

**Objective 1: Annually increase the percent of adolescents/women who talked with a health care professional after delivery about birth spacing or birth control methods.**

**Objective 2: Annually increase the percent of adolescents/women who are engaged in family planning after delivery.**

Healthy birth outcomes, such as low birth weight and preterm birth, are impacted by many factors both before and during pregnancy. Preconception care allows women to talk to their provider about steps to take to promote a healthy pregnancy before conception or implement strategies to delay pregnancy. It also opens the door for early entry into prenatal care. Prenatal care continues to be a crucial method in identifying health issues throughout pregnancy, allowing for early intervention and healthier birth outcomes. Additionally, pregnancy intention is associated with a number of outcomes. Studies have shown that unintended pregnancies are associated with an array of negative health, economic, social, and psychological outcomes for women and children. By implementing interconception and preconception care initiatives, the BFH intends to positively influence birth outcomes.

The rates of women receiving early and adequate prenatal care have been steadily improving with Medicaid and the Affordable Care Act (ACA) increasing access to care. In 2011, 73.2 percent of white women, 56.5 percent of black women and 59.2 percent of Hispanic women received early and adequate prenatal care. However, racial disparities continue to exist with 77 percent of white women compared with 56.2 percent and 59.2 percent of black and Hispanic women respectively receiving prenatal care in the first trimester. Additionally, 1 percent of white women and 4.1 percent and 2.0 percent of black and Hispanic women received no prenatal care.

The BFH has chosen several strategies to address these objectives. Various home visiting models combined with Centering Pregnancy Programs, innovative interconception care initiatives supplemented with motivational interviewing techniques are foundational components for this domain.

Home visiting programs have achieved positive outcomes in reducing the incidence of low birth weight babies, fewer repeat pregnancies, improved child development and increased rates of immunizations. Eight of the ten County Municipal Health Departments offer home visiting programs using the Bright Futures or Partners for a Healthy Baby models. Both curricula allow the home visitor to plan and address key topics at the necessary interval for the family receiving services. The flexibility inherent in these home visiting programs permit women who would not otherwise be eligible for alternate home visiting programs due to repeat pregnancies or delayed enrollment into the program to obtain necessary services.

The BFH will implement current home visiting initiatives as well as expand evidence based programs or curriculum to underserved areas of the state. An expansion plan is currently being developed and additional programs will be expected to begin in January 2016. Home visitors have regular contact with families which allows for comprehensive, family-centered care. This care puts the home visitor in a position to identify any developmental delays the child may be experiencing. Many of the County Municipal Health Departments utilize the Ages and Stages developmental screening tool for identifying developmental delays.

Quantitative studies have shown that women who receive prenatal care through the Centering Pregnancy model compared to traditional prenatal care have: a reduced number of low birth weight babies, reduced number of preterm births, a higher number of prenatal visits and increased breastfeeding rates.

LGH located in Lancaster City and AEHN located in Philadelphia County both struggle with high percentages of low birth weight babies, 10.3 and 10.9 respectively, with racial divides even larger at 12.2 and 13.7 percent. The CPP in these areas aim to improve birth outcomes as well as improve the knowledge base of the participants related to pregnancy and parenting. The BFH will continue to work with LGH and AEHN to offer CPP.

This interconception care project works with children’s scheduled well visits to check on the health of women. Each visit addresses four key components to assess women’s health: smoking status, depression, birth control and folic acid. Women are counseled and referred for services as necessary. This initiative is focused on changing maternal behaviors to improve family health and birth outcomes in subsequent pregnancies. The BFH will work with FMEC to implement this program to be utilized at pediatric provider sites in Pennsylvania.

**Women/Maternal Health - Annual Report**

**NPM 1 - Percent of women with a past year preventive medical visit**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	68	68.7	69.4	70.1	71.4

In the 2010-2015 needs assessment cycle, the Bureau of Family Health priorities for the women/maternal health domain included: decreasing barriers for prenatal care for at-risk/uninsured women through implementation of best practices; and increasing behavioral health screening, diagnosis, and treatment for pregnant women and mothers. Performance measures specific to this domain were: percentage of women who smoke in the last three months of pregnancy; and percent of women with live birth whose observed to expected prenatal visits are greater than or equal to 80 percent of the Kotelchuck index. For both measures, the annual indicators improved each year and BFH met the stated objectives.

To address maternal health priorities, the Division of Child and Adult Health Services (DCAHS) partnered with county/ municipal health departments to provide services in their communities. The county/municipal health departments provide early pregnancy testing to encourage early entry into prenatal care as well as home visiting services to underserved populations to educate on the importance of receiving prenatal care throughout their pregnancy. Through home visiting programs, county municipal health department nurses conduct depression screenings during pregnancy and post-partum periods and make referrals to mental health services as needed. Additionally, in 2014 Montgomery and Philadelphia Counties provided prenatal care to more than 500 uninsurable women who would have otherwise not received prenatal care.

Although the overall rates of prenatal care have improved, racial disparities continue to affect prenatal care numbers across all age groups. From 2010 – 2012, 77 percent of white women compared to 56.2 percent of black women and 57.4 percent of Hispanic women received prenatal care in the first trimester. Additionally, 1 percent of white women and 4.1 percent and 2.0 percent of black and Hispanic women received no prenatal care.

The DCAHS collaborates with LGH and AEHN to provide Centering Pregnancy programs which have shown success in compliance with prenatal care appointments. Of the nearly 400 women who completed the Centering Pregnancy program, 80 percent were compliant with scheduled prenatal care appointments.

Despite the fact that rates of women receiving early and adequate prenatal care have been steadily improving racial disparities remain. In 2011, 73.2 percent of white women received adequate prenatal care compared to 56.5 percent and 59.2 percent of black and Hispanic women respectively.

The Department of Health’s Tobacco Prevention and Control Program (TPCP) has continued to operate the PA Free Quitline with a specialized protocol for pregnant and post-partum users. TPCP provided targeted education and

outreach to the Department of Human Services Managed Care Organizations to increase the number of referrals of pregnant women to the PA Free Quitline, especially in underserved areas.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants.	Increase the proportion of PA birthing facilities that provide recommended care for breastfeeding mothers and their babies.	Facilitate the adoption and implementation of the World Health Organization's ten evidenced based 'steps' for breastfeeding within by PA birthing facilities.	Post neonatal mortality rate per 1,000 live births  Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		
	Starting with reporting year 2015, annually increase the rate of newborns being breastfed in counties with a 2012 rate below 73%.	Target specified counties to implement the evidence based strategies of peer counseling; partner/family support; or media/social marketing.				
	Annually provide breastfeeding information to a minimum of two programs serving MCH populations.	Identify programs throughout the Department and other Commonwealth agencies that serve maternal and child health populations and provide and promote the sharing of breastfeeding information and messages in those programs.				
	Annually implement a minimum of two media opportunities promoting breastfeeding as the infant	Identify media				

**State Action Plan Table**

**Perinatal/Infant Health**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	feeding norm for the state.	events targeting women and families to develop specific messaging that can be utilized across media and implement messaging through identified media opportunities.				
Safe sleep practices are consistently implemented for all infants.	Beginning in the second year of the grant cycle, annually decrease the rate of mothers who report sleeping with their baby in the first year of life.  Annually decrease the percent of infants who are strangled or suffocated due to unsafe sleep environment.	Select and implement evidence based safe sleep strategies.  Hospital certification program/Champions Program	Infant mortality rate per 1,000 live births  Post neonatal mortality rate per 1,000 live births  Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	Percent of infants placed to sleep on their backs		
Appropriate health and health related services, screenings and information are available to the MCH populations.	By 2020, Decrease the time between collection of newborn screening Dried Blood Spot (DBS) to receipt time at	Obtain reports from the Newborn Screening data system  Nursing Service Consultant assigned to quality assurance will review data				

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	contracted lab; to expedite diagnosis and treatment.	NSC will then work with submitters to improve the collection to receipt times				

**Perinatal/Infant Health**

**Perinatal/Infant Health - Plan for the Application Year**

**Domain: Perinatal/Infant Health**

**Priority: Appropriate health and health related services, screenings and information are available to the MCH population.**

**Objective: By 2020, decrease the time between collection of newborn screening Dried Blood Spot (DBS) and receipt time at contracted lab to expedite diagnosis and treatment.**

The objective is to measure the time between collection of the dried blood spot specimen and receipt time at the contracted lab with a goal of all samples being received at the contracted lab within 2 days of collection thus ameliorating the lives of newborns served. The goal will be measured through quarterly data reports provided by PEG and analyzed by the Quality Assurance Nursing Service Consultant (NSC). The NSC will coordinate with PEG to educate hospitals/birthing facilities on their current collection to receipt time, and provide technical assistance to improve collection times. The NSC conducts annual onsite visits to birthing facilities and also conducts numerous webinars through the year to provide program updates and provide education and share best practices.

Pennsylvania state regulations maintain that hospitals/birthing facilities shall send all collected dried blood spot specimens to the contracted lab via first class mail within 24 hours of collection. The Division of Newborn Screening and Genetics has a contract with Perkin Elmer Genetics (PEG) Laboratory to conduct newborn screening blood spot tests on babies born in PA. The lab operates 24 hours a day, 7 days a week, 365 days a year. PEG Laboratory encourages facilities to use The Complete View Solution (ICVS) online tracking system through United Parcel Service (UPS) to send and track filter paper shipments.

Education and technical assistance is provided through onsite visits where the NSC will discuss proper collection procedures, proper storage of collected samples, encouraging submitters to utilize UPS/ICVS; establish policies and procedures within facilities to utilize a log book to verify all filter papers sent have results documented, and encourage mailing filter papers directly from the nursery as opposed to central administration. Hospitals should also be utilizing couriers who know/understand materials being shipped are sensitive.

**Priority: Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants.**

**NPM 4: A) percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**

After the birth of a baby, PA will focus on achieving four objectives to ensure families both initiate and continue breastfeeding their infants. These objectives were determined by the results of previous work educating health care professionals in a variety of settings through the EPIC BEST (Educating Physicians in Community Breastfeeding Education, Support and Training program) as well as from anecdotal feedback from mothers, lactation consultants and the PA Women, Infants and Children (WIC) program. Evaluation results from EPIC BEST targeting healthcare professionals indicated that they had some correct information on breastfeeding pre-education but that they gained a significant amount of knowledge during the session. Additionally, a four to six month follow up has indicated they are making changes in policies and practices to support breastfeeding that would not have occurred without participation in the activities. Anecdotal information provided indicated that many pregnant women were interested in breastfeeding when they discussed this topic with their WIC agency, but when they returned to WIC after giving birth in a PA birthing facility, they lost that desire because they did not feel supported. From this information it was determined that work with healthcare providers needed to continue.

The priority for breastfeeding targets families instead of just mothers in a very intentional manner. Again, past work and feedback has provided an understanding of the importance of the whole 'family' when discussing breastfeeding. Mothers are just one part of the equation so others who support or should support that mother need to be involved in order to ensure success. Focus in the upcoming grant cycle will continue to strengthen support for breastfeeding among fathers, generationally, in 'non-traditional' families and within communities at large.

**Objective 1: Over the next five years, increase the proportion of PA birthing facilities that provide recommended care for breastfeeding mothers and their babies.**

Modeled after the World Health Organization's Ten Steps to Baby Friendly Hospitals Initiative as well as similar initiatives in other states, PA is implementing its Keystone 10 Initiative which focuses on the adoption and implementation of the evidence based ten steps. A regionally based learning collaborative model will be utilized with the facilities to allow group discussion, focus on specific steps, and address similarly encountered barriers to success. Baseline data, like the number of facilities having a breastfeeding policy in place is being collected, and will be monitored for improvement throughout the life of the collaborative. 'Homework' will be assigned in between meetings of the collaboratives and facilitators will provide individualized technical assistance as well. Professionals in participating facilities can partake in limited free educational sessions being offered as part of the initiative to assist them in meeting at least a portion of the educational requirements of the Keystone 10. To assist facilities in meeting their full educational obligations, they will be provided with resources for such courses and will also be asked to consider training a trainer to provide ongoing education within their facilities.

An unanticipated challenge has been the overwhelming interest of facilities in participating in this initiative. Since this was a brand new initiative with no way to gauge interest, initial estimates of facility participation were between 12 and 20 facilities, but when the deadline came, 69 out of 101 birthing facilities had joined in the activity. Neither resources nor personnel were budgeted for that amount of work, however, both assistance from the breastfeeding community as well as flexibility in staff vision allowed the reallocation of resources and personnel to at least start the work. Additional time has been spent devising the plan for the coming years including expanded funding, two additional facilitators, and realigning other work.

**Objective 2: Starting with reporting year 2015, annually increase the rate of newborns being breastfed in counties with a 2012 rate below 73%.**

PA's second objective focuses on providing small grant funds in targeted counties to implement evidence based strategies. Counties being targeted are those with breastfeeding initiation rates below the state's 2012 average of 73 percent. Rates are determined from data collected from PA birth certificates for resident only births and are

calculated on a county level as well as by race/ethnicity for mother, mother's age and baby's birth weight. Focusing on these counties will lead to an increase in the state's overall breastfeeding rate. This type of grant program has been used in the past for breastfeeding activities with much success. Facilities, community based coalitions and community based organizations have used funds to create new programs, purchase needed equipment to facilitate changes in process, provide staff training, and facilitate community level activities. Data gathered indicate processes have changed, staff has been trained and in-facility breastfeeding rates have increased.

Grant funds will be distributed through requests for applications and will be awarded in amounts less than \$10,000; the department's threshold for such a process. Applicants will be given the option of utilizing one to three strategies in their counties to promote breastfeeding: peer counseling, partner/family support and media/social marketing. The applicant will determine which strategy or strategies to utilize and provide a plan of action for specific activities within their county. Partnerships, both formal and informal, will need to be developed and will be integral to the success of the grant activities. Activities will need to be evaluated. The number of grants provided annually will be determined by the allocated budget and it is expected that before the end of the grant cycle sufficient grants will have been issued to cover each targeted county.

**Objective 3: Annually provide breastfeeding information to a minimum of two programs serving MCH populations.**

The third objective focuses on building collaborations with other maternal and child health programs to promote breastfeeding. This will be an effort to promote the use of shared messaging to the maternal and child health populations as well as providers for those populations. An example is the promotion of breastfeeding practices in conjunction with safe sleep practices and programming. Past collaborations with the tobacco cessation program has yielded similar ideas in which healthcare providers are educated about encouraging breastfeeding for women who continue to smoke. Part of the breastfeeding education for healthcare providers is providing them with the understanding of the impact of smoking and giving them options to advise moms to stop smoking but if she does not quit, she can and should still breastfeed and here are the ways to make it safer for the baby. The same is expected of the other programs involved with providing messages about breastfeeding. The greatest challenge to be faced is moving away from program 'silos' and instead focusing on the populations being served. Continued discussions and brainstorming of easy to implement ideas will be used to sway thoughts.

**Objective 4: Annually implement a minimum of two media opportunities promoting breastfeeding as the infant feeding norm for the state.**

The fourth objective centers on promoting breastfeeding as the choice for infant feeding through the use of regular and social media. To control limited funds, free and low cost means of promotion will be sought first but other opportunities will be explored for feasibility. Focus will be varied, targeting not only mothers but fathers, grandparents and 'non-traditional' families as well as young mothers, which statistics indicate breastfeed less, as well as different race and ethnic populations.

**Priority: Safe sleep practices are consistently implemented for all infants.**

**NPM 5: Percent of infants placed to sleep on their backs**

Even after providing programs that reinforce the healthy delivery and positive outcomes of a newborn, we know not all babies achieve adulthood. As a result, Pennsylvania places great focus on infant mortality rates.

Infant mortality is impacted by many aspects which seem beyond the control of practitioners, but safe sleep is truly an area where an impact can be made. As such, the Department recognizes the importance of providing education and outreach to further safe sleep practices across the commonwealth as a means to improve outcomes related to infant mortality.

**Objective 1: Beginning in the second year of the grant cycle, annually decrease the rate of mothers who report sleeping with their baby in the first year of life.**

**Objective 2: Annually decrease the percent of infants who are strangled or suffocated due to unsafe sleep environment.**

Based on a current partnership with the Cribs for Kids Program, the Department has worked collaboratively to promote safe sleep practices to help reduce the incidence of infant death due to SIDS and accidental suffocation and strangulation of infants in bed related to unsafe sleep practices. However, the Department recognizes that additional programming is necessary in order to reduce the rate of caregivers who sleep with their babies in the first year of life. In order to begin programming in 2016, the Department will issue a Request for Proposal in order to fund evidence based programming intended to positively impact the rate at which infants are put to sleep in a safe environment.

An Infant Safe Sleep Summit was held in March 2015, which brought together community partners to help identify strategies and programming which could be adopted to prevent infant death and injury from unsafe sleeping practices. Several best practices were presented and will be considered as new programming is developed and rolled out. Mostly notably, the Department strives to create and deliver one core, consistent message which will be used statewide by providers and partners. Utilizing time at prenatal and postpartum visits, as well as pediatrician and family medicine visits is key in delivering and reinforcing the message.

It is also recognized that current safe sleep education efforts may be the right message at the wrong time. The Department will work with partners to assure that education is provided both at prenatal and post-natal visits and example of strong safe sleep policies are distributed to hospitals for implementation in their nurseries.

**Perinatal/Infant Health - Annual Report**

**NPM-4 A) Percent of infants who are ever breastfed**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	74.0	76.0	78.0	80.0	82.0

**NPM-4 B) Percent of infants breastfed exclusively through 6 months**

Annual Objectives					

	2016	2017	2018	2019	2020
Annual Objective	17.0	18.0	20.0	23.0	26.0

**NPM 5 - Percent of infants placed to sleep on their backs**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.2	79	79.8	80.6	82.1

During the 2010 needs assessment, the BFH identified reducing the infant mortality rate as a priority. In addition, the BFH implemented activities to address the following national and state performance measures:

- The percent of screen positive newborns who received timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.
- The percent of mothers who breastfeed their infants at 6 months of age.
- Percentage of newborns who have been screened for hearing before hospital discharge.
- Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

BFH staff from each division work toward efforts that impact the infant population. The Division of Newborn Screening and Genetics (DNSG) addresses hearing and metabolic screening and follow-up of infants; the Division of Child and Adult Health Services (DCAHS) implements targeted infant mortality reduction initiatives; and the Division of Community Systems Development and Outreach (DCSDO) conducts the Breastfeeding Awareness and Support Program.

The DNSG has a nursing services consultant (NSC) that is responsible for assisting birthing facilities with quality assurance issues as they relate to the PA Newborn Screening and Follow Up Program (NSFP). A 2013 article in the "Milwaukee Journal Sentinel" brought to light the untimely submission of filter papers from hospitals to screening laboratories, and also noted the necessity of a faster collection to receipt time. The NSC shared these statistics with PA facilities and was able to increase collection to receipt time among facilities.

The DNSG contracts with metabolic treatment centers, cystic fibrosis treatment centers and sickle cell treatment centers who receive referrals from the NSFP. These centers work closely with NSFP staff to assure infants who have received a presumptive positive screen are followed through to diagnosis. A recent change for the treatment centers was the use of electronic reporting on the status and diagnosis of referrals. This allowed for increased ease of reporting, uniformity among the various treatment centers and more organized tracking and reporting of cases.

The DNSG has also contracted with Neometrics/Natus to build a state-of-the-art integrated newborn metabolic and screening tracking and follow up system. This system will increase efficiency and reduces cost of program operation by facilitating secure electronic case management and communication with providers.

In October 2014, the PA Legislature mandated Critical Congenital Heart Defect (CCHD) screens to be reported to the DOH. The NSC has worked with facilities and provided training on the reporting mechanism. The DNSG also has been charged with implementing Act 148 of 2014, which adds Lysosomal Storage Disorders (LSD) to the mandatory panel of screening tests for newborns. The BFH will continue to develop the framework for thorough implementation of this legislation.

The DOH again received a grant from HRSA to continue universal newborn hearing screening and intervention. With funding and support from the DOH Newborn Hearing Screening (NBHS) program, in July 2011, the Hands and Voices Guide by Your Side (GBYS) of PA program was launched. Since the inception of the program, parent guides have been available regionally in all areas of the state with experience in a variety of communication options and with diverse diagnoses of their own children such as deaf blindness, sensorineural hearing loss, permanent conductive loss, unilateral loss, many ranges of hearing levels and differing technology choices. Matches between parent guides and families have been made based not only upon geographic proximity, but also upon similarity of diagnoses, hearing levels, communications strategies and technology choices such as cochlear implants or hearing aids. By early 2014, the total number of families served since the inception of the program has reached 230. The provision of direct referrals to GBYS from the DOH NBHS program became a more formalized and consistent process in January 2014, and this has resulted in services being provided to families with children who have hearing loss at a much younger age.

The DCSDO hired a program administrator to fill the Breastfeeding Awareness and Support Program (BASP) coordinator position, effective March 30, 2015. Through a contractual agreement with the American Academy of Pediatrics, focus of breastfeeding activities has been on increasing knowledge about breastfeeding within community based healthcare settings so that they become a source of information and support to pregnant and new mothers regarding breastfeeding. The EPIC BEST (Educating Physicians in Communities-Breastfeeding Education, Support and Training) program is conducted with personnel in primary care OB-GYN, family practices and other locations and practice and policy changes within the setting are encouraged. Six hundred and fifty-one healthcare and related professionals received training through EPIC BEST in 2014. A four to six month follow up survey was conducted with each practice setting that received education. The survey was designed to measure practice and policy changes (ex: development of a breastfeeding policy; recommending exclusive breastfeeding to all pregnant women). Results indicate a significantly higher score in follow up versus prior to having received education.

The DCAHS has numerous initiatives to reduce infant mortality. Various grantees provide portable cribs to families unable to afford a safe sleep environment. When cribs are delivered education on safe sleep, injury prevention and other safety measures are discussed. Cribs for Kids also conducts trainings for police and emergency personnel in order to ensure an infant safe sleep environment exists in any home where they provide services. The Wilkes Barre Health Department provides a smoking cessation program with a focus on pregnant and postpartum women. From July 2013 through June 2014, 323 women received services. Outcomes for this program indicated that 50 percent of women remained smoke free after three months, 30 percent after six months and 25 percent after 12 months.

Additionally, the DCAHS continues to support centering pregnancy and home visiting programs to educate and encourage healthy habits throughout the life cycle and improve the health of mothers and babies in Pennsylvania. The County Municipal Health Departments (C/M) home visiting programs as well as the Lancaster General Hospital (LGH) and Albert Einstein Healthcare Network (AEHN) centering pregnancy programs focus on educating pregnant women on developing a healthy lifestyle with topics such as abstaining from alcohol and drug use, healthy eating, exercise and stress reduction to improve their overall health and reduce their chances of preterm labor.

State Action Plan Table						
Child Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs

<p>MCH populations reside in a safe and healthy living environment.</p>	<p>For each year of the grant cycle, BFH will increase the number of households that receive a home assessment or intervention.</p> <p>For each year of the grant cycle, BFH will increase the number of MCH stakeholders who receive education on healthy homes practices.</p> <p>Annually disseminate 3 simple and clear messages about the dangers of prescription drugs.</p>	<p>Provide comprehensive home assessments to identify potential home hazards.</p> <p>Provide home safety interventions such as integrated pest management and structural repairs to address the leading causes of child injury and death.</p> <p>Provide effective and appropriate training to MCH stakeholders on integrating healthy homes concepts into their work practices.</p> <p>Review and evaluate available social media platforms that can be used for messaging about dangers of prescription drug abuse.</p>	<p>Child Mortality rate, ages 1 through 9 per 100,000</p> <p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <p>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</p> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p>	<p>Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19</p>	
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**Child Health**

**Child Health - Plan for the Application Year**

**Domain: Child Health**

**Priority: MCH populations reside in a safe and healthy living environment**

**NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 19**

As a result of the 2015 MCH Needs and Capacity Assessment, the BFH identified the priority for MCH populations to reside in a safe and healthy living environment. The living environment encompasses not only the physical structure of the home, but also the behavioral and emotional factors that apply within a living environment or neighborhood. Children who are exposed to physical hazards such as contaminants, pests, and moisture issues are at risk for injuries or illnesses. Children may also be exposed to drug use, violence, and domestic abuse in their home and neighborhood environments. By beginning to address factors contributing to injuries during childhood that happen in or around the home, the BFH anticipates a reduction in the child mortality rate and the rate of hospitalization for non-fatal injuries.

Low-income people and communities across the United States suffer disproportionately from the negative health effects of poorly constructed, unsafe and substandard housing. A number of research studies have documented these negative effects, which include asthma and other respiratory illnesses, cardiovascular health problems, increased stress, and adverse overall physical and mental health status. In addition to affecting the quality of life for low-income people, these health problems also place a significant burden on the health care system.

Pennsylvania's Child Death Review (CDR) program was developed to promote the safety and well-being of children by reducing preventable childhood fatalities. This is accomplished through systemic, multi-agency reviews of the deaths of children under the age of 21. The CDR Program facilitates the death review process, provides training and technical assistance to local teams and makes recommendations regarding prevention programs and policies. The BFH uses these data and team recommendations to inform program goals and interventions.

**Objective 1: For each year of the grant cycle, BFH will increase the number of households that receive a home assessment.**

In 2013 the BFH implemented the Lead and Healthy Homes Program (LHHP), using the evidence-informed models of home assessment, education, housing rehabilitation and integrated pest management (IPM) to establish an evidence-informed home assessment and education program to identify and improve the health and safety of homes and their residents. The healthy homes approach is a coordinated, comprehensive, and holistic approach to preventing diseases and injuries that result from housing-related hazards and deficiencies. In addition to issues related to the structure of homes the LHHP has highlighted the need for education and teaching on practices and behaviors that lead to safe and healthy homes.

The BFH will use the results of LHHP analysis and the MCH needs assessment to inform healthy homes programming going forward. Future programming will incorporate American Academy of Pediatrics guidance and interventions to reduce the risks of injuries, and continue to provide limited housing rehabilitation and education to address safe and healthy home issues. Falls, poisoning and hot objects are leading causes of injuries leading to hospitalizations in Pennsylvania, especially in the MCH population. Several interventions aimed at reducing these hazards in order to prevent injuries are supported by research that ranges from proven to promising. In addition, LHHP will utilize CDR data and recommendations whenever it is practicable to improve interventions that may be specific to a region or population.

Falls are the leading cause of injuries that result in hospitalization in Pennsylvania and for children under age 15. Falls can be the result of structural issues as well as unsafe practices and behaviors. Studies demonstrate that home modification does reduce hazards and is therefore promising as a way to reduce falls and fall injuries. Home modification may include installing window guards and repairing faulty stairs or floor surfaces.

Poisoning causes one out of every ten injuries that require hospitalizations in Pennsylvania and rises to almost a quarter of the injuries for people ages 15-24. Poisoning occurs when products or medicines are used in the wrong way, in the wrong amount or by the wrong person. Every 10 seconds, a poison control center in the United States answers a call about a possible poisoning with more than 90% of these exposures occurring in the home and 80 percent being unintentional. Half of poisonings occurring in children under age six are from cosmetics and personal care products, which are completely preventable.

Carbon monoxide (CO) is a colorless, odorless gas that is created by the burning of fuel that can be deadly to people. Because CO cannot be seen or smelled, it can only be detected if a working CO detector is properly installed. Despite CO poisoning being preventable, more than 400 Americans die from unintentional CO poisoning not linked to fires, more than 20,000 visit the emergency room, and more than 4,000 are hospitalized.

Hot objects/substances are the second leading cause of hospitalizations related to injuries for children under age five in Pennsylvania and nationally scalds are the leading cause of burn injuries to children under age four. Reducing water heater temperature to 120°F is one of the easiest interventions to reduce the risk of hot water burns. Educational efforts alone and education paired with safety equipment have been shown to be effective for children of various ages, genders, races, and ethnicities. Such efforts have demonstrated effects for children in single parent and two-parent households, children living in rental units, and children in family-owned homes.

Pesticides are used in about three out of four U.S. homes to prevent or kill bugs or rodents and are poisonous to people. Pesticides are often used in large quantities in low income, urban areas. Integrated Pest Management (IPM) is a broad range of methods to control pests that also minimizes potential hazards to people, property, and the environment. Individually tailored IPM plans can be cost-effective, with costs that are often equal to or lower than traditional chemical pest control. IPM begins with the least risky approaches (e.g., mechanical controls such as trapping) and moves to targeted pesticide use only if other measures are not successful to control pests while also reducing pesticide exposure, in order to improve health outcomes and improve housing conditions. When used in low income urban areas, IPM strategies can reduce disparities in pesticide exposure and related health risks, especially for children.

Lead exposure remains a concern for children and the major causes of elevated blood lead levels among U.S. children are lead-based paint and lead dust. Houses built before 1978 are likely to contain some lead in the paint which becomes a problem when it deteriorates or is destabilized during renovations.

In the coming year, the BFH will more directly address the leading causes of injuries that can occur in and around the home as part of the LHHP. Through the LHHP the BFH has seen improvements in the quality of home environments for the MCH population through education and low cost interventions. With several modifications, the BFH believes that both quantitative and qualitative analysis will reflect improvements in a variety of health and safety measures.

The BFH works with regional contractors to provide the home assessments and education to identify and improve the health and safety of homes and their residents throughout the state. Low-cost evidence-informed interventions that reduce injuries and provide for healthier homes are greatly needed and include smoke alarms, CO alarms, IPM. For home hazards that impact the health of the residents and are unable to be addressed by the property owner or other housing programs, limited funds are available for evidence informed remediation activities. The services provided by the LHHP fill a long standing void.

**Objective 2: For each year of the grant cycle, BFH will increase the number of MCH stakeholders who receive education on healthy homes practices.**

The BFH will implement the LHHP as the primary Healthy Homes program serving the MCH population. In order to improve the delivery of public health services, the BFH will also explore and identify additional avenues to increase the number of healthy homes programmatic practices by partnering with other programs through the BFH, the Department of Health, or other public and private partnerships.

Through its childhood lead surveillance program BFH tracks and monitors childhood lead testing activity through the Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS). PA-NEDSS is a web-based application used for laboratory reporting and analysis of diseases, and includes lead test results of Pennsylvania's children. Using childhood lead data from PA-NEDSS, the program can identify possible high-risk areas, locate areas of low testing and identify other potential service gaps.

The BFH serves as a statewide resource on healthy homes to provide information and referrals to appropriate organizations.

BFH will identify strategies for addressing safe and healthy living environments by providing data, education, and training opportunities, using the expertise and evaluation of the LHHP and its partners. The BFH anticipates expanding the healthy homes messaging to other entities that work with the child population, especially in an in-home setting. The LHHP regional contractors will continue to provide a high level overview of healthy homes concepts to medical and social service providers to increase general knowledge and provide talking points for interactions with families. Not only does this result in referrals to the LHHP, but improves the workforce by equipping providers with a better understanding of the causes, impacts and resources for safe and healthy homes issues. This is especially important for home visitors who are able to directly observe the conditions and behaviors in and around the home. Furthermore, the BFH will explore opportunities to collaborate with other program areas, including the Pennsylvania Departments of Transportation, Environmental Protection, and Education, and the Violence and Injury Prevention Program to address safe and healthy neighborhoods. Since many children are injured in the living environment surrounding their home, BFH will consider the feasibility of developing strategies to reduce childhood injuries from deteriorating neighborhood playgrounds, unsafe walking routes, and violence.

Currently, the BFH operates a toll-free Lead Information Line to provide information and resources on prevention, screening, abatement and regulatory issues on lead for the citizens of Pennsylvania. Going forward, the BFH will analyze the volume and type of calls to determine if there are opportunities to provide education about lead or other healthy homes issues related to the kinds of inquiries that are most often received.

**Objective 3: Annually disseminate three simple and clear messages about the dangers of prescription drugs.**

PA CDR data, as well as other national and state hospitalization data and vital statistics indicate a growing incidence of children and adolescents who are injured or die due to poisoning or overdose of prescription drugs. Prescription drugs are widely regarded as safe because they are prescribed by a doctor, but when they are not used as prescribed or for whom they are prescribed, there are a variety of negative physical and psychological consequences.

The family environment and the process of socialization can impact children's behaviors and decisions about drug use. Parents or family members who use prescription drugs for non-medical reasons are likely to share their opinions about drug use and possibly even their drugs with their children, thus normalizing the behavior of taking drugs without first seeing a doctor. Through the LHHP, BFH will increase messaging about the appropriate use of

prescription drugs. However, in order to reach a wider population, BFH will explore and identify promising avenues to disseminate information to the child population, using effective strategies both for the type of message that is used and the manner in which it is shared. BFH recognizes that the problem of prescription drug abuse is large and multi-faceted and there is not one simple solution to alter the trend. By attempting to change the view during childhood about what is normal and healthy, BFH aims to prepare children to have the right information they need to make better decisions about drugs as they grow to adulthood.

**Child Health - Annual Report**

**NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	188.7	186.8	184.9	183.1	179.3

State priorities in the 2010 needs assessment cycle that addressed child health were to increase screening for mental health issues among infants, children, and adolescents; and expand injury prevention activities for infants, children, and adolescents. The BFH has collaborated with other state agencies or Department of Health programs to address several critical child health needs, including immunizations, violence and injury prevention, insurance, and obesity prevention.

BFH provides primary and preventive health services for children through a variety of means. To screen for mental health services, county municipal health department nurse home visitors use the Ages and Stages Social Emotional screening tool to identify early signs of social or emotional problems. Nurses make referrals to appropriate treatment and follow-up as needed.

The Philadelphia Department of Public Health and the Wilkes-Barre City Health Department provide programs to educate children about healthy lifestyles. The programs encourage and organize physical activities as well as education on improving dietary habits. Additional education is offered to parents and caregivers to provide guidance and support to the child outside of the program.

BFH programs work with families to obtain age-appropriate vaccinations from their primary care provider, federally qualified health centers, or additional services. Immunizations for school-age children who are uninsured, underinsured, or enrolled in Medical Assistance are available from the Vaccines for Children program, implemented within the Department of Health.

BFH, in partnership with the Department of Human Services and the PA Chapter of the American Academy of Pediatrics oversees the Child Death Review (CDR) Program throughout the state. The CDR program was developed to promote the safety and well-being of children by reducing preventable childhood fatalities. This is accomplished through systemic, multi-agency reviews of the deaths of children under the age of 21. All 67 Pennsylvania counties are represented on local CDR teams. The CDR Program facilitates the death review process, provides training and technical assistance to local teams and makes recommendations regarding prevention programs and policies.

Development and implementation of prevention measures vary according to the community and the findings of the local CDR Team. Some of the prevention measures that have been implemented focus on motor vehicle safety, suicide prevention, safe sleep and farm safety. The intent is that prevention measures will reduce the death rate of

children. BFH staff collaborate with the Violence and Injury Prevention Program and participate on the Injury and Violence Prevention Network, which works to develop a comprehensive and coordinated injury prevention effort.

In order to take a closer look at why children are dying in Pennsylvania and apply lessons learned from information gleaned from local CDR teams, BFH developed and delivered a two day training to address Sudden Unexplained Infant Death Scene Investigation and related topics including the importance of safe sleep. Curriculum was aimed at providing cross system training to improve and foster collaboration and communication among those who are involved in all aspects of infant and child death investigations, with the ultimate goal of improving standards by which Pennsylvania responds to such deaths.

The Lead and Healthy Homes Program (LHHP) staff work with families to identify and address potential home hazards to prevent injuries and illness. LHHP often works in conjunction with other home visiting or early education program and conducts home assessments to identify factors that could contribute to injuries or illness, and provide education and interventions to reduce risk factors. Additionally, environmental inspections are performed in homes of children with elevated blood lead levels. LHHP staff members develop partnerships to integrate safe and healthy housing activities at the local level with other housing and health programs. Many home hazards are remedied by low-cost interventions or simple behavioral changes, but without the appropriate assistance, families may be unable to identify or remediate hazards on their own. BFH oversees grants with regional grantees to provide services across the state. LHHP was fully implemented July 1, 2013 in four of the six state health districts. By July 1, 2014, the program was implemented throughout the state. In 2014, 1,200 families were served and over 20,000 supplies were distributed, including low-cost safety devices, pest control, and non-toxic cleaning supplies. BFH staff members have provided technical assistance and ongoing evaluation to identify areas for improvement in program implementation.

As part of the Federal Traumatic Brain Injury (TBI) grant, the BFH is the lead agency in a number of initiatives aimed at increasing awareness regarding brain injury, including training to increase awareness of and screening for TBI in athletes of all ages; screening youth in juvenile justice facilities in order to identify individuals with TBI and assure the provision of appropriate services; and education of physicians specific to TBI recognition and management.

State Action Plan Table						
Adolescent Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Protective factors are established for	Increase the number of adolescent health vendors receiving	Provide evidence-informed LGBTQ cultural competency training to BFH	Adolescent mortality rate ages 10 through 19 per 100,000	Percent of adolescents, ages 12 through 17,		

**State Action Plan Table**

**Adolescent Health**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
<p>adolescents and young adults prior to and during critical life stages.</p>	<p>training to improve rates of intervention when bullying/harassment is witnessed and increase the number of supportive staff available to LGBTQ youth.</p> <p>Annually increase the number of BFH vendors serving adolescents that adopt and implement comprehensive anti-bullying/harassment policies that specifically enumerate sexual orientation, gender identity, and gender expression as protected categories with clear and effective systems for reporting and addressing incidents that youth experience.</p> <p>Increase the number of adolescents participating in a bullying awareness and prevention</p>	<p>vendors who serve adolescents.</p> <p>All vendors serving adolescents through a BFH grant will be required to adopt and implement comprehensive anti-bullying/harassment policies.</p> <p>Select and implement evidence based strategies from models such as Olweus.</p>	<p>Adolescent suicide rate, ages 15 through 19 per 100,000</p>	<p>who are bullied or who bully others</p>		

**State Action Plan Table**

**Adolescent Health**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	program.					
Protective factors are established for adolescents and young adults prior to and during critical life stages.	<p>Annually increase the number of LGBTQ sensitive organizations which provide services to youth.</p> <p>Annually increase the number of LGBTQ youth who have access to suicide prevention services.</p>	<p>Implement an evidence-informed approach to train youth-serving organizations to become a safe space for LGBTQ youth.</p> <p>Implement an evidence-based suicide prevention training for LGBTQ youth.</p>				
Protective factors are established for adolescents and young adults prior to and during critical life stages.	<p>Annually increase the number of youth who report achieving development assets.</p> <p>Annually increase the number of evidence-based or evidence-informed mentoring, counseling, and adult supervision programs available to youth ages 9 - 14.</p>	<p>Implement evidence based or evidence-informed mentoring, counseling, and adult supervision programs for youth ages 9 - 14.</p>				
Adolescents and women of child-bearing age have	In the first year of the grant cycle, BFH will increase from baseline SFY	Expand the evidence-informed HRC model to nine additional counties.	Adolescent mortality rate ages 10 through 19 per 100,000	Percent of adolescents, ages 12 through 17,		

State Action Plan Table

Adolescent Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
<p>access to and participate in preconception and inter-conception health care and support.</p>	<p>2014-2015 data, the number of counties with a Health Resource Center (HRC) available to youth ages 12-17 either in a school or community based setting.</p> <p>Beginning in the second year of the grant cycle, the BFH will annually increase the number of youth ages 12-17 utilizing HRC services.</p> <p>For the duration of the grant cycle, the BFH will increase from baseline SFY 2014-2015 data, the number of LGBTQ youth with a medical visit in the past year.</p> <p>Starting with reporting year 2015, BFH will increase the number of youth receiving health education and counseling services during a reproductive health visit.</p>	<p>Expand to a second service site in each of the nine counties identified in year one and work with the HRC sites to increase the number of youth receiving services.</p> <p>Utilize LGBTQ organizations to provide drop-in services, for high-risk and LGBTQ youth. The services shall include primary medical care and support services.</p> <p>Make available office visits and counseling/health education to youth as part of a reproductive health visit at a family planning provider.</p>	<p>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</p> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p> <p>Percent of children with a mental/behavioral condition who receive treatment or counseling</p> <p>Percent of children in excellent or very good health</p> <p>Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</p> <p>Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza</p> <p>Percent of adolescents,</p>	<p>with a preventive medical visit in the past year.</p>		

**State Action Plan Table**

**Adolescent Health**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
			<p>ages 13 through 17, who have received at least one dose of the HPV vaccine</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</p>			

**Adolescent Health**

**Adolescent Health - Plan for the Application Year**

**Domain: Adolescent Health**

**Priority: Protective factors are established for adolescents and young adults prior to and during critical life stages**

**NPM 9: Percent of adolescents, ages 12 – 17, who are bullied or who bully others.**

Lesbian, Gay, Bisexual, Transgender and Questioning/Queer (LGBTQ) youth experience higher rates of bullying and harassment than their non-LGBTQ peers. In a 2013 report, a majority of Pennsylvania’s LGBTQ youth regularly heard anti-LGBTQ remarks at school, had been victimized at school, and did not have access to in-school resources and supports. Due to the lack of support for these youth, 57 percent of students who were bullied never report it to school staff. Among those students who did report bullying to staff, only 37 percent said reporting resulted in effective intervention by staff. While these statistics are specific to youth attending school, youth in placement also experience bullying and harassment, at even high rates. A study found 78 percent of LGBT youth were removed or ran away

from their placements as a result of hostility toward their sexual orientation or gender identity.

**Objective 1: For the duration of the grant cycle, BFH will increase from SFY 2014-2015 data the number of adolescent health vendors receiving training to improve rates of intervention when bullying/harassment is witnessed and increase the number of supportive staff available to LGBTQ youth.**

**Objective 2: For the duration of the grant cycle, BFH will increase from SFY 2014-2015 baseline data the number of adolescent health vendors that adopt and implement comprehensive anti-bullying/harassment policies that specifically enumerate sexual orientation, gender identity, and gender expression as protected categories with clear and effective systems for reporting and addressing incidents that youth experience.**

The BFH has prioritized the need for protective factors to be established for adolescents and young adults by focusing on evidence-informed recommendations made by the Gay, Lesbian and Straight Education Network (GLSEN) in their 2013 National School Climate Survey. These recommendations include providing professional development for staff on LGBT youth issues and implementing comprehensive anti-bullying and harassment policies.

In the coming grant cycle the BFH will collaborate with a LGBTQ service organization to provide evidence-informed cultural competency training to all BFH vendors serving adolescents. Through programs including Reproductive Health Services, the Personal Responsibility Education Program (PREP) and Healthy Youth PA (Title V Abstinence Education Grant Program), the Bureau contracts with a variety of youth-serving organizations including family planning councils, partial/outpatient drug and alcohol programs, and residential facilities serving delinquent youth. Staff at these organizations will be provided with LGBTQ cultural competency training with a focus on bullying and harassment prevention and intervention.

The BFH will require all adolescent health vendors to implement comprehensive anti-bullying and harassment policies. Policies will be required to specifically enumerate sexual orientation, gender identity, and gender expression as protected categories. There should be clear and effective systems for reporting and addressing incidents that students experience. By working together with adolescent health grantees, the BFH intends to decrease the percent of adolescents, including LGBTQ youth, who bully or have been bullied.

**Objective 3: Increase the number of adolescents participating in a bullying awareness and prevention program.**

Youth violence and bullying are major public health issues for individuals, families, and communities. Both are complex problems which, over time, impose serious effects on targets and bystanders and serious consequences on aggressors. Solutions require widespread, sustained efforts in families, schools, and communities.

There is no one single cause of bullying among children; individual, family, peer, school, and community factors can place a child or youth at risk for bullying. These factors work individually, or collectively, to contribute to a child's likelihood of bullying. Family risk factors for bullying include: a lack of warmth and involvement on the part of parents; overly-permissive parenting (including a lack of limits for children's behavior); a lack of supervision by parents; harsh, physical discipline; parent modeling of bullying behavior; victimization by older brothers. Peer risk factors for bullying include: friends who bully; friends who have positive attitudes about violence; some aggressive children who take on high status roles may use bullying as a way to enhance their social power and protect their prestige with peers; some children with low social status may use bullying as a way to deflect taunting and aggression that is directed towards them, or to enhance their social position with higher status peers.

The BFH will use lessons learned from the Virginia Department of Health in the implementation of their Youth Violence and Bullying Prevention efforts. The BFH will identify the various areas where bullying awareness prevention strategies can be implemented. There are a number of adolescent serving programs supported by Title V through which prevention and interventions can be implemented. The BFH also has a strong relationship with the Department of Education and will assess the ability to partner to implement the Olweus model. LGBTQ youth and CYSHCN are particularly vulnerable populations and as such will be of particular focus for the prevention strategies. Attention also needs to be given to children who are bullied as well as undertaking systemic strategies to reduce the number of children who view bullying as an appropriate behavior.

**Objective 1: For the duration of the grant cycle, BFH will increase from baseline SFY 2014-2015 data the number of LGBTQ sensitive organizations which provide services to youth.**

**Objective 2: For the duration of the grant cycle, BFH will increase from baseline SAF 2014-2015 data the number of LGBTQ youth who have access to suicide prevention interventions.**

Suicide is the second leading cause of death among adolescents ages 10 to 24, and suicide attempt rates increase for LGBTQ youth. Numerous studies reveal suicide ideation and attempts were three to seven times higher among gay and lesbian youth than heterosexual youth. Rates increase even higher among LGBTQ youth who come from highly rejecting families. Factors contributing to higher rates of suicide include depression, substance abuse, and victimization. The BFH intends to establish protective factors for LGBTQ youth through a partnership with Persad Center, an LGBTQ-focused human service organization.

For the duration of the grant cycle, the BFH will support the Persad Center's engagement in coalition building activities with known ally organizations and new partners to become Safe Space certified. A Safe Space organization or individual is defined as an ally who can provide support and information to LGBTQ individuals. The Persad Center's Safe Space program focuses on youth 14-21 years old and trains organizations on a number of topics including how to create inclusive programs, how to address harassment, and how to meet the needs of LGBTQ youth of color and transgender youth. The BFH intends to provide a place for LGBTQ youth where they feel supported and accepted.

The Persad Center will implement the Yellow Ribbon Suicide Prevention program through support from the BFH, for the duration of the grant cycle. This evidence-informed approach has three components: personnel are trained to be gatekeepers and how to effectively respond in a suicidal crisis; parents, grandparents and guardians are educated on how to respond effectively to their child's depression and suicidal ideation; the student body is trained to understand the causes of suicidal despair, recognize warning signs and risk factors and how to intervene appropriately with an at-risk friend. The Yellow Ribbon Suicide Prevention program will be implemented at the Persad Center's after school program at the Gay and Lesbian Community Center in Pittsburgh, Pennsylvania and within the Erie County School District.

Within the adolescent health domain, also related to the priority: Protective factors are established for adolescents and young adults prior to and during critical life stages, the BFH will be establishing a state performance measure: Percent of youth ages 9-17 receiving mentoring, counseling and adult-supervision programming.

**Objective 1: Annually increase the number of youth who report achieving development assets.**

**Objective 2: For the duration of the grant cycle, the BFH will increase from baseline SFY 2014-2015 data**

**the number of evidence-based or evidence-informed mentoring, counseling, and adult supervision programs available to youth ages 9-14.**

The BFH is using an approach that utilizes evidence-based or evidenced-informed programming that combines mentoring, adult-supervised activities, adult-led group discussions, and parenting education as a means to increase the protective factors of youth ages 9-14. Providing opportunities for youth to increase the number of protective factors they have is the primary organizing concept of this approach. By utilizing the Search Institute's 40 Developmental Assets framework, youth will be provided with building blocks for healthy development to help them grow into healthy, caring and responsible young adults.

Research conducted by the Search Institute has documented the significance of developmental assets in protecting youth from many different harmful or unhealthy choices. The Search Institute's developmental assets framework includes 20 external assets organized under the following four categories: support, empowerment, boundaries and expectations, and constructive use of time; and 20 internal assets organized under these four categories: commitment to learning, positive values, social competencies, and positive identity.

The developmental assets serve as protective factors to help youth avoid negative risky behaviors. The positive effects of these protective factors increase as the number of assets a youth has increases. Enhancing the developmental assets of youth provides an opportunity for them to transition into sexually healthy adolescents who are able to realize their individual potential around critical developmental tasks related to sexuality.

**Priority: Adolescents and women of child-bearing age have access to and participate in preconception and interconception health care and support.**

**NPM 10: Percent of adolescents, ages 12-17, with a preventative medical visit in the past year.**

**Objective 1: In the first year of the grant cycle, BFH will increase from baseline SFY 2014-2015 data the number of counties with a HRC available to youth ages 12-17 either in a school or community based setting.**

**Objective 2: Beginning in the second year of the grant cycle, the BFH will annually increase the number of youth ages 12-17 utilizing HRC services.**

Adolescents encounter many barriers when attempting to get needed health care including fear of lack of confidentiality, transportation issues, and inconvenient appointment times and costs. The BFH aims to address and eliminate these barriers through the Health Resource Center (HRC) model. The following core services will be provided to HRC clients:

- sexual and reproductive health education
- confidential, individual-level counseling
- screening for chlamydia, gonorrhea and pregnancy
- referrals and direct linkages to core family planning services
- dissemination of condoms and other risk reduction tools

HRCs are located in high schools and community-based organizations so services are easily accessible.

In the first year of the grant cycle, the BFH will, in partnership with AccessMatters, expand the HRC model beyond the present sites in Philadelphia and Delaware counties to nine additional counties. Counties included in the expansion were determined by their high rates of teen pregnancy, gonorrhea, chlamydia, high-school dropouts and binge

drinking. Beginning in the second year of the grant cycle, a second site will be added to each of the nine high-need counties.

**Objective 3: For the duration of the grant cycle, the BFH will increase from baseline SFY 2014-2015 data the number of LGBTQ youth with a medical visit in the past year.**

LGBTQ youth experience the same range of health challenges as heterosexual youth in general, but when seeking care, insecurities may rise due to social stigma and biased medical providers. Medical providers may assume clients are heterosexual, and LGBTQ youth often are afraid to disclose their sexual orientation or gender identity to health care providers.

For the duration of the grant cycle the BFH will partner with the Mazzoni Center, a health care provider who serves the LGBTQ community, to provide drop-in services for high-risk and LGBTQ youth at the Mazzoni Center’s medical center. In addition to primary medical care, support services and basic necessities (food, public transportation tokens, etc.) will be provided. In addition, the BFH will partner with a LGBTQ center in the central part of the state to replicate the Mazzoni Center drop-in center to serve LGBTQ youth in this geographical area.

**Objective 4: Starting with reporting year 2015, BFH will increase the number of youth receiving health education and counseling services during a reproductive health visit.**

The BFH will partner with the four Title X family planning councils in the Commonwealth to provide youth under the age of 17 with health education and counseling services during a reproductive health visit. Per the Quality Family Planning Guidelines issued jointly by the CDC and the Office of Population Affairs, adolescents are to be provided with additional counseling on how to prevent a pregnancy, communicating with parents/guardians, and shall be presented in a teen friendly environment. To meet these guidelines, providers need to spend additional time counseling youth beyond the standard office visit. Therefore, the BFH will fund office visit and counseling codes to allow providers to spend additional time with adolescents during a reproductive health care visit. The quality family planning guidelines also acknowledge that a reproductive health visit in many cases is the only usual health care that adolescents and women are receiving, therefore, it is critical that providers have additional time to spend with adolescents to make sure all of their healthcare needs are being addressed.

**Adolescent Health - Annual Report**

**NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14.5	14.3	14.1	13.9	13.7

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	86.9	87.8	88.7	89.6	91.2

In the 2010 needs assessment cycle, state priorities that addressed adolescent health included: decrease teen pregnancy through comprehensive sex education; expand injury prevention activities, including suicide prevention; and expand access to physical and behavioral health services for high risk youth, including LGBTQ and runaway/homeless. Oversight of adolescent health programs lies within the Division of Child and Adult Health Services (DCAHS).

The DCAHS provides programming on abstinence and contraception to prevent pregnancy and sexually transmitted infections, and three adulthood preparation subjects through Personal Responsibility Education Program (PREP) funding. Nine hundred and seven at-risk youth completed an evidence-based program (either Street Smart or the Rikers Health Advocacy Program) at a PREP facility. Obstacles to implementation include struggles with recruitment and retention at outpatient and partial PREP implementation sites. To address these obstacles and improve numbers of youth reached, PREP sites provided participant incentives and condensed implementation schedules. The DCAHS supports teen pregnancy prevention services through AccessMatters, who uses these funds to provide a variety of services to high school students through the Health Resource Center (HRC) program. The HRC program provides sexual and reproductive health education; confidential, individual level counseling, screening for chlamydia, gonorrhea, and pregnancy testing, referrals and direct linkages to core family planning services, and distribution of safer sex materials (male and female condoms and dental dams). AccessMatters operates HRCs in nine Philadelphia area schools, with plans to total twelve schools by April 2015. In addition, the DCAHS supported the four family planning councils in the Commonwealth to provide reproductive health services to adolescents age 17 years and younger. Services were provided to 13,517 adolescents in 2014.

The DCAHS has posted the "Teen Game Plan" and companion adult guide on the Department's website. The "Teen Game Plan" was designed to help youth think about their future and how the decisions they make now will impact their future and ability to reach their goals. Topics covered in the "Teen Game Plan" include financial security, emotional health, and sexual health. The Safe Teens website, which is an interactive educational website aimed at teens to provide them with information and resources. Last year, the website had over 64,000 visitors. Features have been added to the Safe Teens website to increase traffic and length of stay on the site. Additional features are being worked on to improve the Educator's Corner as an ongoing effort to drive more educators to the website.

All 67 counties of Pennsylvania actively participate in local Child Death Review (CDR) teams. When examining the death rates for the three-year period of 2009-2011, suicide ranked third in the causes of death in children 1-21 years of age comprising 11.9 percent of deaths. Closer examination revealed children 15 through 17 years of age had the highest rate of deaths due to suicide. Local CDR teams recognized the need to focus on suicide prevention activities including: Yellow Ribbon Campaign, presentations in schools, sub-review groups to specifically look at suicide prevention, developing a suicide prevention taskforce, establishing a local chapter of the American Foundation for Suicide Prevention, and supporting Student Assistance Programs.

The DCAHS provided funding to Persad Center to implement the Yellow Ribbon Suicide Prevention Program, which reached 348 youth this year. They utilize this program in their After School Program at the Gay and Lesbian community center in Pittsburgh and in the Erie County School District. The program is used to raise awareness of suicide prevention in the community. Additionally, Persad Center provided presentations to two schools that they anticipate will present the information to the students in the future.

The DCAHS continues to support Persad Center and Mazzone Center to provide services to LGBTQ youth. Persad Center implements the Safe Spaces Project, which provides suicide prevention training to youth, and engages in coalition building activities with known ally organizations and new partners to help the organizations become Safe Space certified. Mazzone Center provides a drop-in health center for youth to obtain a variety of health care and

social services. Mazzoni Center also provides training on health disparities related to sexual orientation, gender identity and appropriate standards of care for LGBTQ individuals and LGBTQ cultural competency training to medical, behavioral health and social service providers. The professional trainings have been well received by workshop attendees, and included feedback such as, "My favorite part of the workshop was the discussion around sexual identity, gender expression, and gender identity. I loved this workshop." The popular demand of training requests allowed Mazzoni to hire a full-time trainer for LGBTQ topics.

Persad Center provided 715 people with Safe Space training as part of becoming Safe Space certified in 2014. Mazzoni Center provided 3,058 youth with medical services at the drop in health center, 2,167 youth received case management visits, and 2,387 were services provided to unduplicated youth.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Appropriate health and health related services, screenings and information are available to the MCH populations.	Starting with reporting year 2015, increase the number of fully implemented medical home practices in PA	<p>Physicians who operate their practice as a medical home utilize ongoing quality improvement.</p> <p>Practices engage and support family/consumer partnerships such as parent partners, family and youth advisors.</p> <p>Practices support cross systems work.</p> <p>Practices use best practice tools and resources.</p>	<p>Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system</p> <p>Percent of children in excellent or very good health</p> <p>Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations</p> <p>Percent of children 6 months through 17 years who are vaccinated</p>	Percent of children with and without special health care needs having a medical home		

**State Action Plan Table**

**Children with Special Health Care Needs**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
			annually against seasonal influenza <hr/> Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine <hr/> Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine <hr/> Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

**Children with Special Health Care Needs**

**Children with Special Health Care Needs - Plan for the Application Year**

**Domain: Children with special healthcare needs**

**Priority: Appropriate health and health related services, screening and information are available to the MCH population.**

**NPM: Percent of children with and without special healthcare needs having a medical home**

**Objective 1: Starting with reporting year 2015, increase the number of fully implemented medical home**

## practices in PA

A medical home is not a building or a place. It is an approach to providing comprehensive primary care that facilitates partnerships between patients, clinicians, medical staff, and families. The medical home concept is defined by the following six components: accessible, continuous, comprehensive, patient and family centered, coordinated, compassionate, and culturally effective. There are currently 74 practices in PA who are actively participating as medical homes.

The BFH will implement medical homes across the state using the four main components of medical home: Physicians who operate their practice as a medical home utilize ongoing quality improvement; Practices engage and support family/consumer partnerships such as parent partners, family and youth advisors; Practices support cross systems work; Practices use best practice tools and resources.

Medical home practices routinely seek the feedback of families in an attempt to operate in a manner that best suits the patients. Practices develop, distribute and evaluate surveys that are mailed to the families following their visit. Survey results are evaluated by the medical home grantee and feedback is shared with the individual practice so issues can be discussed and changes implemented as necessary. This method of ongoing practice improvement keeps the practice knowledgeable about issues that may seem insignificant but can become problematic if not addressed.

Each practice typically recruits several family members to serve as parent partners; individuals who are trained to work with other parents who need support and who can offer feedback on the practice experience. Parents are recruited by the practice and provided with information about the day-to-day working of the office and how they can be part of the office team. Parent partners typically attend meetings where they are asked to comment on items that could be improved upon and offer solutions to ongoing issues. Parent partners facilitate meetings for new and existing families whose children are patients. During those meetings, education is provided on new systems and open dialogue is encouraged. The BFH grantee helps practices recruit and train parent partners for this role. Parents are invited to attend the biannual meetings held by the grantee and subsistence is provided so they do not have to incur out of pocket costs. The grantee has helped to train over 200 parents to fill this role and family satisfaction surveys indicate that the support provided has helped many as they deal with difficult situations.

Practices work amongst themselves and with other practices to learn from each other about various ways to offer better care. Practices attend monthly conference calls and biannual conferences where they learn about a particular topic and can spend free time touching base with other practitioners. In addition, practices work with other grantees and agencies other than DOH to learn about the programs funded by the agency and to hear of any best practices that have been developed which can be of benefit to the practice.

Practices use tools like the patient registry and other documents including the care plan which enables the staff to get to know the patient and their needs. These two documents list specifics about the patient including cultural and ethnic background information that may be helpful when verbally communicating with the family and when offering printed material to support specifics discussed during the office visit. The care plan is developed so that both practice and family can have a document that addresses the needs of the patient including those which can have impact on the patient should the family not be available at the time of an emergency. Practices use the service of a care coordinator to support the family with issues like locating a specialist, obtaining appointments and necessary equipment, and locating support for parents who are having trouble accepting or coping with a new diagnosis.

Medical home practices work to make their environment including office hours accessible for their patients. Many practices routinely offer evening and weekend hours to make it easier for families to schedule appointments.

Practices operate in this fashion in order to put the needs of the patients first and encourage the family to ask questions and offer recommendations. Practices attempt to schedule patients with the same physician so care can be consistent and the family does not need to spend valuable time updating the physician on the needs of the patient. Appointments for children with special needs are typically scheduled for longer blocks of time so the physician, patient, and family have time to evaluate the patient's needs and discuss any questions the families may have.

## Children with Special Health Care Needs - Annual Report

### NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50	50.5	51	51.5	52.5

The Bureau of Family Health (BFH) has implemented multiple programs and established partnerships to address the needs of the Children with Special Health Care Needs (CSHCN) population. For the project cycle of 2010-2015, the priorities and performance measures that addressed the needs of the CSHCN population included: improving the transition from child to adult medical, educational, and social services; increasing respite services for caregivers; improving family partnerships in decision-making for CSHCN and overall satisfaction with care; receiving coordinated, ongoing, comprehensive care within a medical home; obtaining adequate insurance coverage for needed services; improving access to a well-functioning community-based system; and receiving needed referrals for specialty care/services without a problem.

BFH has implemented several initiatives that provide improved access to services, medical homes, transition, and respite care for CSHCN and their families. The PA Medical Home Program (MHP) continues to be one of the strongest programs in the country. The BFH has revised the way it defines its fully implemented medical homes - the current number is 74. Within those 74 medical homes, there are 505,555 children, and 29,959 CSHCN. The MHP has 198 Parent Partners working within the practices. The MHP conducted Learning Collaboratives for MHP teams on parent engagement. Educational sessions were held on topics including transition to adult healthcare, disaster and emergency preparedness, NCQA certification, and HIPAA.

An ongoing challenge has been the public's lack of understanding of what a "medical home" is and how it can benefit their children. Also, there are numerous organizations claiming to have "medical homes" that are not part of the PA Medical Home Program and may not meet the same criteria. The MHP adheres to the Educating Practices in Community Integrated Care (EPIC IC) model, including use of the Medical Home Index, Patient Registries, Care Coordination, Family Surveys, and analysis of data.

In addition, the BFH has implemented initiatives to assist CSHCN with transitioning to adulthood. Health impacts all aspects of a person's life and, for that reason, CSHCN face more barriers than other youth as they enter into adulthood and work toward fulfilling aspirations related to independent living, employment, relationships and

recreation. Issues involving insurance, finding doctors, managing personal medical records, navigating the health care system, and understanding their medical conditions can consume their lives.

The BFH has distributed 1,157 Transition Health Care Checklists to youth, families and professionals to help youth assess their transition readiness. The BFH sponsored scholarships for YSHCN to attend the annual Transition Conference, where they have had the opportunity to hone their self-advocacy skills. PA MHP, with the Parent Education and Advocacy Leadership (PEAL) Center and the Children's Hospital Advisory Network for Guidance and Empowerment (CHANGE) developed educational materials to help CSHCN transition from pediatric to adult health care.

A major barrier to obtaining adequate insurance coverage is that many families are unaware of the availability of insurance coverage and the range of services available to meet the needs of their CSHCN. To address this, the BFH has promoted the Children's Health Insurance Program (CHIP), Medical Assistance, Healthy Kids helpline, and COMPASS systems to increase families' awareness of and access to adequate insurance. The PA Medical Home Program (PA MHP) practices work with families on insurance issues and promote awareness of the "Ops Memo", which allows pediatric patients to have covered visits for both pediatric and adult visits during the period of transition from pediatric to adult health care. The PA MHP utilizes their patient registries to collect data on insurance status and educate practices about insurance changes.

The Special Kids Network works closely with the Bureau of Managed Care Organizations (BCMO) and their Special Needs Units to assist families with insurance problems. Callers to the Healthy Baby line are connected to the Medical Assistance program as appropriate. Social workers at specialty care clinics assist families with obtaining needed medical insurance/Medical Assistance. The BFH continues to promote awareness of insurance options and has had speakers provide updates on the Affordable Care Act at appropriate venues, typically utilizing the expertise of the PA Health Law Project.

CSHCN are often under the care of multiple specialists that are not available in one location, thus creating a need to make multiple visits to different locations and for many patients/families, transportation can be challenging. Parents are often overwhelmed by the challenges of caring for their CSHCN and become frustrated by the lack of one single point of contact for all statewide resources. The BFH aims to improve access to necessary information for CSHCN and their families through several avenues. One key to assisting families to easily identify and access services is ensuring that agencies serving CSHCN collaborate and share information. The Special Kids Network (SKN) Elks nurses and Regional Coordinators work with families to hear and address issues. The Epilepsy program held parent-led "community conversations" to increase awareness of services. The MHP has held parent engagement learning collaborative and has a Facebook page "Especially for Parents". The BFH published articles on SKN and the Family Advisor in publications targeted towards families, and a regular e-mail blast was sent to partners with updates on the BFH's programming for CSHCN. The BFH regularly meets with partners such as Parent to Parent, PEAL, the State Interagency Coordinating Council for Early Intervention, and the PA Developmental Disabilities Council. The multidisciplinary clinic format used by the specialty care grantees helps ensure services and information is readily available to families and eases families' burdens of seeing many specialists for a condition. In 2015, the SKN expanded from six to eight Regional Coordinators, which will allow for better statewide coverage. Partnerships continue to grow among state agencies and other partners to assure broad-based knowledge sharing of resources. The Department of Health has updated its website to better organize information about programs.

The BFH implemented the TakeFIVE respite care program. Through a contract with Temple University, BFH recruited faith and community organizations to participate in training on how to train volunteers and operate a respite program. The organizations began providing respite care to caregivers of CSHCN and have received ongoing technical assistance. To date, over 16,000 hours of respite have been provided under this initiative to 318 CSHCN.

BFH utilizes several platforms to improve involvement of families in decision-making for CSHCN. The Special Kids Network (SKN) provides three core components to support families of CSHCN: the toll-free helpline; in-home service coordination, and a system of community and regional support. The SKN Regional Coordinators held 10 Parent Youth Professional Forums, 122 Family Gatherings, and 16 SKN meetings. SKN Elks Nurses conducted 4,228 home visits to provide service coordination, including teaching parents self-advocacy. The Family Advisor gave presentations to and met with parents to facilitate their awareness of services and hear the family perspective. The MHP focuses on family-centered care utilizing Parent Advisors and Parent Partners.

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
MCH populations are able to obtain, process and understand basic health information needed to make health decisions.	Beginning in the first year of the grant cycle, disseminate at least one simple and clear messages about basic health information.	Review and evaluate available social media platforms that can be used for messaging of basic health information.  Explore the feasibility of using a text messaging or smart phone app outreach program to provide basic health information.				
Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.	Annually decrease percent of women who report smoking during pregnancy.  Annually decrease	Utilize the Integrated Screening Tool (5Ps)-Institute for Health and Recovery  Utilize Motivational Interviewing	Rate of severe maternal morbidity per 10,000 delivery hospitalizations  Maternal mortality rate per 100,000 live births	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

State Action Plan Table

Cross-Cutting/Life Course

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	percent of women who report smoking after pregnancy.		<p>Percent of low birth weight deliveries (&lt;2,500 grams)</p> <p>Percent of very low birth weight deliveries (&lt;1,500 grams)</p> <p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <p>Percent of preterm births (&lt;37 weeks)</p> <p>Percent of early preterm births (&lt;34 weeks)</p> <p>Percent of late preterm births (34-36 weeks)</p> <p>Percent of early term births (37, 38 weeks)</p> <p>Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>Infant mortality rate per 1,000 live births</p> <p>Neonatal mortality rate per</p>			

State Action Plan Table

Cross-Cutting/Life Course

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
			1,000 live births <hr/> Post neonatal mortality rate per 1,000 live births <hr/> Preterm-related mortality rate per 100,000 live births <hr/> Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births <hr/> Percent of children in excellent or very good health			
Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.	Annually increase number of women receiving Title V funded prenatal care or home visiting who are screened for behavioral health. <hr/> Annually increase the percentage of women with a home visitor who have a conversation about intimate	Utilize the Integrated Screening Tool (5Ps)-Institute for Health and Recovery <hr/> Utilize Motivational Interviewing				

**State Action Plan Table**

**Cross-Cutting/Life Course**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	partner violence (IPV)					
<p>Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.</p>	<p>Annually identify at least one area for improvement in collecting or using data for each BFH program.</p> <hr/> <p>Staff from each BFH program will conduct analysis to develop actionable goals annually.</p> <hr/> <p>Staff from each BFH program with actionable findings will develop and implement at least one programmatic strategy based upon the findings during the project period.</p> <hr/> <p>Existing data collection programs will increase the dissemination of data to improve public health outcomes.</p>	<p>Review program activities and goals to determine programmatic needs.</p> <hr/> <p>Identify and utilize at least one staff resource to conduct analysis, interpret results, and develop actionable reports.</p> <hr/> <p>Develop program strategies based on actionable findings</p> <hr/> <p>Staff will use PA PRAMS findings to inform, develop, modify and evaluate public health programs and policies in Pennsylvania.</p> <hr/> <p>Staff will conduct analyses of childhood lead data to inform</p>				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
		public health programs and policies.				

**Cross-Cutting/Life Course**

**Cross-Cutting/Life Course - Plan for the Application Year**

**Domain: Cross-Cutting or Life Course**

There are a number of factors that contribute to poor maternal and infant outcomes and particularly disparate outcomes for African American women and babies. These factors include mental health, smoking and other substance abuse, intimate partner violence, poor housing, unsafe neighborhoods, institutional racism and stress. During the preconception and interconception periods are times when women having access to a trusted health care practitioner is valuable, and opportunities for important conversation about the concerns identified above. Data analyzed through PRAMS surveys suggests that when women have had a health care practitioner talk to them about these issues, there is recognition and value in these conversations as preventative measures or interventions.

The Bureau of Family Health (BFH) is planning strategies and activities on several cross cutting and life course issues that are contributing to negative health conditions in the state as well as those which, when improved, will lead to overall health improvement of the citizens of Pennsylvania. The state priorities that are addressed in the life course domain are that MCH populations are able to obtain, process and understand basic health information needed to make appropriate health conditions; and women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.

**Priority: Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.**

**Objective: Annually increase the number of women receiving Title V funded prenatal care or home visiting who are screened for behavioral health.**

Prescription medications are commonly used by a large portion of the population for a number of conditions. Most Americans take drugs for legitimate reasons but others use the drugs for non-medical use. Because drugs are so widely available, the risk of getting used in a manner other than how or for whom they are intended is high, whether the use is accidental or intentional. Prescription drugs are widely regarded as safe to take because they are prescribed by a doctor, but when misused they became dangerous and can impact all stages along the life course. When prescription drugs are not used as prescribed or for whom they are prescribed, there are a variety of negative physical and psychological consequences. The negative health effects from prescription drug addiction differ little from consequences of illicit drugs. Individuals who become addicted may lose their jobs, damage their family relationships, and even lose their homes. Prescription drug abuse may also be a gateway to the abuse of illicit drugs. The most commonly abused drugs are OxyContin, Vicodin, Xanax, Soma, and Fentanyl, a relatively new drug

of abuse. These drugs cause more deaths than heroin and cocaine combined.

Nonmedical use of prescription painkillers is especially widespread among young adults between the ages of 18-25. In 2011, 5 percent of this population group stated that they misused prescription painkillers. One survey in 2011 found that 17 percent of 7<sup>th</sup> to 12<sup>th</sup> graders had used prescription pain medication to get high or change their mood at least once in their lifetime, 10 percent had abused prescription drugs in the last 12 months, and 6 percent reported doing so in the past 30 days. From 2009-2013, poisoning was the leading cause of hospitalization for the 15-24 age group. In 2011, Pennsylvania's child death review data shows that poisoning is the second leading cause of death for the 18-21 age group, and of the poisoning deaths reviewed, prescription drugs were the most common substance involved.

The family environment and the process of socialization can impact children's behaviors and decisions about drug use. Parents who use prescription drugs for non-medical reasons are likely to share their opinions about drug use and possibly even their drugs with their children, thus normalizing the behavior of taking drugs without first seeing a doctor.

The Department of Drug and Alcohol Programs and the Department of Health are taking steps to address the systemic problems associated with rampant non-medical use of prescription drugs. Strategies include establishing a statewide database for prescription drug monitoring, legislation that makes Naloxone available for law enforcement officials, friends, or family members of opioid addicts, prescription drug drop-off sites, and training for physicians and pharmacists about best practices in prescribing and dispensing opioid medications.

The BFH recognizes that prescription drug abuse or misuse impacts MCH populations at all stages, but will be incorporating strategies into Title V programming beginning with the pregnant/maternal population. By assessing behavioral health issues during the prenatal period, BFH aims to identify and address potentially risky behaviors or circumstances in order to improve pregnancy outcomes, as well as improving health for children and families in the same household. Although prescription drug abuse is a major problem, BFH will not be solely focusing on prescription drugs. Instead, BFH will incorporate the use of an evidence-informed screening tool – the Integrated Screening Tool (5P's), to screen for behavioral health issues. The Integrated Screening Tool is a non-threatening, quick, and conversational tool that assesses risk for alcohol, substance abuse, violence, and depression based on 5 P's: Parents, Peers, Partner, Pregnancy, and Past. The tool guides clinicians to make referrals or recommendations based on responses. The Integrated Screening Tool asks questions about drug or alcohol use by parents or peers as a way to open up the conversation about substance abuse. Women, especially during pregnancy, may be hesitant to talk about their own drug use habits, but are willing to share about the habits of their parents or peers.

Through grant agreements with local agencies who provide either prenatal care or home visiting services, the BFH will include the use of the Integrated Screening Tool with other grant activities. For agencies or staff who have not used the Integrated Screening Tool, BFH will provide training and will also support the local MCH workforce to identify appropriate referral sources for further assessment and treatment as needed.

In addition to the Integrated Screening Tool, BFH will train home visiting program staff to use motivational interviewing techniques, which have been proven to be effective in instilling behavior change. Home visiting program nurses have the unique advantage of being trusted enough to spend time with women in their homes and with their families. By integrating proven tools into the work that is done in the home, BFH anticipates an improvement in the number of women who are screened for behavioral health issues and the likelihood that they will receive needed follow-up services.

**Objective: Annually increase the percentage of women with a home visitor who have a conversation about intimate partner violence (IPV).**

Intimate partner violence (IPV), also known as domestic violence, battering, or spouse abuse, includes physical, sexual, emotional, verbal and financial abuse and occurs in both genders, among the young and old, rich and poor, within heterosexual and same-sex couples and does not require sexual intimacy. In Pennsylvania, 37.7 percent of women and 27.5 percent of men experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime. CDC estimated the costs of intimate partner rape, physical assault, and stalking in excess of \$5.8 billion each year, nearly \$4.1 billion of which is attributable to direct medical and mental health care services, nearly \$0.9 billion in lost productivity from paid work and household chores for victims of nonfatal IPV and \$0.9 billion in lifetime earnings lost by victims of IPV homicide.

An analysis of the 2007 through 2010 PA PRAMS survey response data revealed significant association between IPV and maternal age, maternal education and maternal race/ethnicity. Mothers under 25 years of age were more likely to report experiencing physical abuse before and during their pregnancies than mothers 25 years of age and older. Mothers with less than 12 years education were more likely to report experiencing physical abuse than mothers with more than 12 years education. Stress and life choices were also contributing factors, with mothers indicating that if their husband or partner had told them they didn't want the pregnancy they were approximately 5.7 times more likely to have experienced physical abuse during pregnancy. Those having reported stress related to a husband or partner losing a job were 3.7 times more likely to have experienced physical abuse during pregnancy. And those reporting a separation or divorce were approximately 8.4 times more likely to have reported physical abuse by a husband or partner during pregnancy.

Changing the picture of IPV necessitates recognizing all its characteristics and focusing on changing attitudes, particularly among those key populations groups that see higher rates of such violence. BFH will use existing programs to begin assessing IPV and assisting vulnerable individuals with resources they need to avoid being harmed in their relationships.

The Integrated Screening Tool includes a question about feeling unsafe in one's relationship. BFH home visiting programs will adapt their curriculums or models in order to include the Integrated Screening Tool and appropriate follow-up recommendations and referrals. The BFH anticipates using its MCH Home visiting program and Lead and Healthy Homes Program as the initial pathways for conducting the Integrated Screening Tool. BFH will also explore the feasibility of adding the tool to programs for adolescents or parents of CSHCN, whether services are provided in homes or not, and expanding ways to address IPV in vulnerable groups.

**NPM 14: A) Percent of women who smoke during pregnancy**

**Objective: Annually decrease the percentage of women who report smoking during pregnancy.**

Smoking in pregnancy has many potentially harmful consequences for both mother and fetus, including premature birth, low birth weight, the potential for certain birth defects and serves as a risk factor for Sudden Infant Death Syndrome. Approximately 10% of women reported smoking during the last three months of pregnancy, and, although many try to quit, four in ten relapsed within six months after delivery.

BFH has opportunities to impact women during the prenatal period through Home Visiting and prenatal care programs. In the coming year, BFH will require that local Title V agencies or other funded partners who provide these

services to attend training on the Integrated Screening Tool and Motivational Interviewing, and incorporate screening and referrals into their programs. Home visiting programs, Lead and Healthy Homes Program, and Centering Pregnancy Programs currently perform different kinds of assessment, referrals, or education to women about smoking during pregnancy. By using a consistent and reliable tool and techniques, BFH expects improvements in the number of women who smoke during pregnancy.

**NPM 14: B) Percent of children living in households where someone smokes**

**Objective: Annually decrease the percent of women who report smoking after pregnancy.**

Exposure to environmental tobacco smoke (ETS) causes disease and premature death among nonsmokers. Specific health consequences for infants and children include more frequent and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS). While true to all populations, and especially for growing and developing children, there is no safe level of exposure to ETS. Nearly three out of every ten children live in a household with a smoker; the rates are higher for CSHCN and those under the poverty level.

The BFH will leverage the array of MCH programs, most notably home visiting programs to more comprehensively integrate education on the effects of ETS. Specifically, the BFH will review program materials and procedures for opportunities to include or enhance referrals for the PA Free Quitline, Pennsylvania's primary smoking cessation resource. BFH will provide training to home visiting programs regarding motivational interviewing in order to effect behavior change. The BFH will use the Integrated Screening Tool and will use motivational interviewing practices to make and follow-up on referrals.

The BFH will analyze PA PRAMS data to identify potential correlations between circumstances surrounding a woman's pregnancy and her likelihood to report smoking after pregnancy. Current data suggests that of the women who reported that they quit smoking while they are pregnant, breastfeeding was the most common behavior associated with women who reported that they did not relapse smoking after the pregnancy. In the coming year, BFH will continue to develop strategies to address smoking through the life course, using current data and evidence-based or informed practices.

**Priority: MCH populations are able to obtain, process, and understand basic health information needed to make appropriate health decisions.**

**Objective: Beginning in the first year of the grant cycle, disseminate at least one simple and clear message about basic health information.**

A clear and often articulated need of the MCH population expressed during the stakeholder focus groups was for the BFH to use technology to provide information on available resources to both stakeholders and the MCH population. They suggested that information be available not only through the DOH website, but also through social media and texting platforms. The breadth of topics included information about specific conditions, initiatives, services, resources and general MCH/Title V knowledge.

In the past, neither the DOH nor the BFH had been actively engaged in the distribution of information using social media and texting. But recently, the DOH has launched both a Facebook page now with over 400 likes and a Twitter account with nearly 300 followers. Both continue to grow.

With few exceptions, the literature largely consists of observational studies describing users and usages of social

networking sites regarding topics of public health interest. More studies that fully exploit the communication tools embedded in social networking sites and study their potential to produce significant effects in the overall population's health are needed.

A substantial body of research has shown that health text messaging programs can bring about behavior change to improve short-term smoking cessation outcomes as well as short-term diabetes management and clinical outcomes (increasing frequency of blood glucose monitoring and reducing HbA1c levels). Research has also shown that text messaging improves treatment compliance, including both medication adherence and appointment attendance. Research suggests that text messaging can improve immunization rates, increase sexual health knowledge, and reduce risky behaviors related to HIV transmission, although the literature is less definitive in these areas.

The BFH, through stakeholder feedback and a growing body of research, sees the potential for increasing our presence on social media platforms, text messaging and smart phone apps. As such, beginning in the first year of the grant cycle, the BFH will explore new avenues to disseminate simple and clear messages about basic health information. While the number of DOH Facebook likes and Twitter followers appears low, the messages may be reaching greater audiences with sharing. Further research will be needed with the DOH Office of Communications to determine the reach. Just over three out of four teens owns a cell phone and so does nearly nine out of every ten adults, but smart phones have not reached such a saturation level and are owned by just over a third of teens and over half of adults. It will be important then, for the BFH to explore the feasibility of using these technologies (text messaging and smart phone apps) as outreach and engagement tools to provide basic health information.

While the use of social media platforms, text messaging and smart phone apps remain in the early stages, the BFH anticipates that any use of this type of technology would support MCH evidence-based programs and programming to assist MCH populations in obtaining, processing, and understanding basic health information needed to make appropriate health decisions.

## Cross-Cutting/Life Course - Annual Report

### NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14.0	13.7	13.2	13.0	12.8

### NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	28.3	27.3	26.3	25.3	24.3

In the prior needs assessment cycle, there were no priorities that specifically addressed the life course perspective, but the BFH has implemented several initiatives that cut across more than one population domain. In addition, though many programs or services focus on a single population domain, the services that are offered work to either

increase protective factors or reduce risk factors and may mitigate some of the multiple stressors that a family faces. BFH has also provided education and some training to staff and partners about the Life Course Perspective as it relates to maternal, infant, and child health outcomes. BFH has supported the county municipal health departments in implementing pre-conception and interconception health programs that begin to address social determinants of health in order to improve health outcomes.

To address cross-cutting performance measures for the MCH populations, the BFH complements services that are provided by other bureaus within the Department of Health or other state agencies. The Department of Human Services oversees dental and oral health services that are provided the Medical Assistance (MA) program. In Pennsylvania, dental sealants are a covered dental benefit for children enrolled in MA. However, only 17.8 percent of children who were eight years old and enrolled in Medical Assistance received a dental sealant on at least one permanent molar in 2014. To increase the number of children having access to dental care, the BFH has supported local Title V agencies in providing dental services for children. The Allentown City Bureau of Health, Montgomery County Health Department and the Wilkes-Barre City Health Department provide dental services in their communities. Services are provided to children, through the age of 21, who are uninsured, underinsured or uninsurable. Essential services such as routine examinations, cleanings, extractions and fillings are combined with education related to oral health care. In 2014, 545 individuals received dental services through these programs.

The Pennsylvania Department of Human Services oversees the Children's Health Insurance Program (CHIP) in addition to the MA program. Through these programs, all children in Pennsylvania are eligible for no-cost or subsidized health insurance. Approximately 5.4 percent of children in Pennsylvania in 2014 were uninsured. Through nearly all Title V programs, MCH program staff assist families in identifying resources to apply for and be enrolled in MA or CHIP if they have not already done so. In addition, county municipal health departments, and BFH programs such as the Lead and Healthy Homes Program, Special Kids Network, and Family Advisor assist families with identifying routine and specialty benefits for which they are eligible.

The Lead and Healthy Homes Program (LHHP) provides services that cut across multiple population domains and address potential hazards within the home. Though the program focus is on primary prevention of home-related illness and injury, the LHHP also provides low-cost interventions and education for existing home hazards, such as safety concerns, moisture intrusion or water damage, and integrated pest management. By addressing such hazards, the LHHP anticipates a reduction in the number of injuries as well as missed school or work days due to asthma hospitalizations or emergency department visits. In some cases, addressing these problems in the home allows families to proceed with services for which they may not otherwise have been eligible, such as the Weatherization Assistance Program or Lead Hazard Control Program. To implement the LHHP, BFH has grant agreements with four grantees who provide services throughout the state. In 2014, LHHP provided services to 1,200 families and distributed over 20,000 supplies.

The Pennsylvania Pregnancy Risk Assessment Monitoring System (PA PRAMS) is an ongoing, population-based surveillance system designed to identify and monitor selected maternal experiences and behaviors that occur before and during pregnancy and during the child's early infancy. Even though the PA PRAMS questionnaire refers to experiences before, during pregnancy and shortly after a baby is born, the survey measures a wide variety of experiences that have implications during multiple life stages. This includes information about access to medical care and insurance, what messages they receive from their doctor, how safe they feel in their home and neighborhood, what kind of social support network they have, and whether or not they smoke or use other drugs. PA PRAMS data is part of the national PRAMS dataset and has been analyzed in multiple studies to identify trends in birth outcomes associated with other maternal circumstances. Pennsylvania contracts with the Bloustein Center for Survey Research at Rutgers University to conduct data collection by mail and telephone surveys. PA PRAMS has maintained a response rate above the required threshold of 65 percent necessary for scientific validity every year

since implementation in 2007. In 2014, BFH initiated a data sharing project with WIC to obtain telephone numbers for PA PRAMS operational staff. Because telephone numbers are not part of the Pennsylvania birth certificate, obtaining telephone numbers from WIC increased the overall response rate, and it decreased the amount of time and resources dedicated to locating telephone numbers through other means.

### **Other Programmatic Activities**

Pennsylvania has selected a state priority to build capacity of Title V staff and programs to collect, analyze, and use data. By building this capacity, the Bureau of Family Health (BFH) anticipates a positive impact across all of the population health domains. While the BFH has several programs that are strong in collecting and using data for program evaluation and decisions, the 2015 Needs and Capacity Assessment revealed that there are not consistent practices in place across the BFH and in the local MCH workforce. To systematically address this, BFH has developed objectives and strategies to build capacity in an intentional manner, similar to the way objectives and strategies are created to serve population needs. By investing in this capacity, BFH will be better equipped to understand the needs of the MCH population and make informed decisions about programmatic investments.

**Priority: Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.**

**Objective 1: Annually identify at least one area for improvement in collecting or using data for each BFH program.**

To start the process of transforming data into programmatic strategies, staff will annually identify at least one area for improvement in collecting or using data for each program. Part of this process will be for staff to review their program activities and goals to determine programmatic needs. After needs are identified, staff can then research what data sources are available to meet programmatic needs. These can include research studies, information and surveillance systems; national, state, or local data; information from vendors, and operational reports from other related programs within or outside of the bureau. These data sources will be documented for future reference. The data available can then be compared to the data needed, and where there are gaps, other activities can be pursued to address them. For example, staff can conduct an analysis of the processes that are used to collect the information, and examine areas of inefficiency or document where needs aren't being met. Both of these steps will lead to improvements in data collection, which strengthen the ability to meet programmatic needs.

**Objective 2: Staff from each BFH program will conduct analysis to develop actionable goals annually.**

Once compiled, the data needs to be analyzed, interpreted and transformed into useful findings. To this end, staff will conduct analysis of the data and develop actionable goals on an annual basis. Since data analysis capability varies across programs, a resource must first be identified and engaged in order to conduct the routine analysis. This may be a program administrator, someone within the division, within the bureau, or even outside of the bureau that has the knowledge and skills to analyze and interpret the data. Because of this variability in data analysis capability, staff will have the opportunity to work on data projects across different programs, in a number of ways, including research, data analysis and geospatial analysis. The results of the analysis will then be utilized to develop actionable recommendations and goals for program improvements.

**Objective 3: Staff from each BFH program with actionable findings will develop and implement at least one programmatic strategy based upon the findings during the project period.**

Since programs will have varying data sources and types, actionable reports will be tailored to specific

programmatic needs. The objective will be to develop and integrate at least one programmatic strategy based upon relevant information and findings. Program staff will first have to review and prioritize potential strategies from the compilation of actionable findings. The next step would be to prioritize strategies, and decide which ones to pursue. Some potential activities include the determination of target populations for intervention, whether or not to pilot a particular operational strategy within a particular program or vendor. Since the applicable population for this objective includes Title V program staff and program vendors, staff will consider whether to implement the strategy as a part of program administration at the central office, or to integrate the strategy into vendor activities. With programs that do not have vendors, or strategies that do not apply to vendors, implementation of the strategy will likely only occur at the central office. But for programs that contract with vendors, the strategy could apply to vendor activity, and would therefore need to be integrated into the work plan, communicated with the vendor, and possibly additional training. This may lead to ongoing discussion with the vendors regarding programmatic data collection needs, and could result in modification of the strategy, or the pursuit of a different strategy altogether.

**Objective 4: Existing data collection programs will increase the dissemination of data to improve public health outcomes.**

The Pennsylvania Pregnancy Risk Assessment Monitoring System (PA PRAMS) is an ongoing population-based surveillance system designed to identify and monitor selected maternal experiences and behaviors that occur before and during pregnancy and during the child's early infancy. It is a good example of a program that collects and uses data to increase understanding of maternal behaviors and experiences. PA PRAMS data is analyzed and translated into usable information for planning and evaluation of public health programs and policies. As a program, it is a significant contributor in ongoing efforts to build state capacity for collecting, analyzing and translating data to address maternal and infant health issues. Staff currently conduct descriptive analyses on PA PRAMS data to improve understanding of maternal health behaviors and prevent adverse health events. In the coming year, staff will identify opportunities to disseminate PA PRAMS findings to key stakeholders and increase analytic capability in order to inform, develop, modify and evaluate public health programs and policies in Pennsylvania.

The Childhood Lead Surveillance Program is another example of an existing data collection program, but one that focuses on a single public health issue. Childhood lead data is reported to the Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS), a statewide surveillance database that stores patient, test, and provider information for all reportable diseases in Pennsylvania. Staff will access the childhood lead data in PA-NEDSS with customizable data extraction software, and analyze the data to provide data on topics such as lead testing activity, blood lead levels, and areas where there may be gaps in service. The BFH will identify areas of need and opportunities to disseminate targeted or statewide data to programs or organizations that may be able to use this data to inform decision-making for the purpose of improving public health outcomes.

**Other Programmatic Activities:**

BFH supports other critical partnerships with MCHB programs such as the Maternal, Infant, Early Childhood Home Visiting (MIECHV) grant, administered by the Pennsylvania Office of Child Development and Early Learning. BFH staff participate on the MIECHV home visiting stakeholder group to share best practices and collaborate on home visiting initiatives. While the goals for MIECHV and Title V are slightly different, there is mutual benefit in sharing resources and information about successes, challenges, and population needs.

The BFH receives state and federal funding to address newborn screening and metabolic conditions through its Division of Newborn Screening and Genetics (DNSG). Pennsylvania follows the lead of the federal Secretary's Advisory Committee on Heritable Diseases in Newborns and Children with respect to adding conditions to the state screening panel. Currently, the mandatory and follow-up panel of screening tests for newborns includes 29

conditions. In October 2014, the PA Legislature mandated Critical Congenital Heart Defect screens to be reported to the DOH. The NSC has worked with facilities and provided training on the reporting mechanism. The DNSG also has been charged with implementing Act 148 of 2014, which adds Lysosomal Storage Disorders (LSD) to the mandatory panel of screening tests for newborns. The BFH will continue to develop the framework for thorough implementation of this legislation and anticipates implementation in the fall of 2015.

The Newborn Screening program utilizes a Technical Advisory Board to provide expert medical advice and guidance on program improvement/medications. As experts in fields of metabolic disease, genetics, and neonatology, they have firsthand knowledge of patient needs, industry changes and current practices so as to promote the programs to a leading edge forefront.

Early in 2014, the Bureau began a procurement process for the development of a new IT solution for the DNSG. The Department also spent a great deal of time looking at the management of technology resources. The new system comes from Natus and is called iCMS. It is an enterprise system for newborn screening and case management and will work with metabolic screenings as well as the different techniques for hearing screenings. iCMS is an internet based system that will allow staff to automatically generate letters, manage follow-up on cases and create a referral and diagnosis audit trail. Lab Imports will occur hourly and results reports from the lab will be entered into the system, thus decreasing the time it will take staff to begin follow-up procedures for newborns.. Implementation of the iCMS system is scheduled to begin in the fall of 2015, with DOH staff utilizing the system (Phase 1). Stakeholders will begin using the system in 2016 during Phase 2.

## **II.F.2 MCH Workforce Development and Capacity**

The Bureau of Family Health (BFH) works in conjunction with local Title V personnel to serve the MCH population throughout the state. BFH and local Title V staff represent a diverse background of educational and career experiences and are well qualified to administer and provide program services. At the state level, 55 staff are employed by Title V and at the local level 133 staff are employed to provide statewide services. Of these, 56 staff are employed to provide services for Children with Special Health Care Needs (CSHCN).

The director of the BFH serves as the state MCH Director. Effective February 20, 2015, the position of BFH Director was vacated and a permanent director has not yet been appointed. The role of the BFH Director is to lead, monitor, and plan programming for the BFH and the MCH populations in alignment with the Title V state priorities, the mission and vision of the Department of Health (Department), and the capacity of the BFH. The bureau director is also responsible for assessing and implementing development opportunities for the MCH workforce, at both the state and local levels. In the absence of a permanently appointed BFH Director, Carolyn Cass, Director of the Division of Child and Adult Health Services has been serving as the Acting Director of the BFH.

Michelle Connors serves as the state's Title V Children with Special Health Care Needs Director. As the Director of the Division of Community Systems Development and Outreach, Ms. Connors also oversees multiple projects that focus on Children with Special Health Care Needs and their families.

Many of the BFH division directors and program managers have served in their positions for greater than five years, and have worked in the public health field for even longer. Many local Title V agencies also have dedicated staff and vast experience in working with MCH populations. The BFH works with the Department of Health Human Resources Office and Office of Legal Counsel to assure that staff are provided with ongoing training in regards to the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), and Equal Employment Opportunity topics. In addition, the BFH has been working since 2014 with the National Center for Cultural Competence (NCCC) to provide training and professional development to local Title V staff on cultural competency. Training sessions included Communicating Across Cultures: The Essential Role of Linguistic Competence, Family-Centered Care and Cultural Competence: Two Sides of the Same Coin, and Understanding and Responding to Cultural Differences Among Families of Children with Special Health Care Needs. Lesbian, Gay, Bisexual, Transgender and Questioning training was provided to all BFH staff and for many community based agency staff.

BFH staff have been participating with the Cultural Competence Taskforce (CCT), comprised of Department employees who represent the diverse populations of Pennsylvania. This group is developing training courses related to cultural competence, cultural sensitivity, culturally and linguistically appropriate services standards, health literacy, and the effects of diversity, poverty, and other social determinants of health on populations the Department serves. These training courses, including face to face and online, will be offered to Department employees highlighting how the healthcare workforce can communicate effectively with diverse populations.

BFH staff also strive to improve the MCH workforce by providing or supporting topic-specific training as needed for state and local Title V staff. Local Title V agency grants often include funding to support professional development of staff to attend accredited or nationally sponsored training workshops in order to remain current on emerging issues and best practices, and to hone their skills in working with the BFH population. To support the MCH workforce and increase the effectiveness of services and interventions the BFH will incorporate training and integration of motivational interviewing techniques in MCH programming over the course of the grant cycle.

At the state level, the BFH Director and Division Directors seek out appropriate opportunities to improve the skills of BFH employees through training or professional development. In 2015, BFH and local Title V staff attended the MCH Epidemiology/CityMatCH Leadership Conference; training course in MCH Epidemiology; Association of Maternal & Child Health Programs (AMCHP) annual conference; an eight week technical assistance online course offered by the Public Health Informatics Institute; and numerous program-specific trainings and webinars.

The BFH is confident that the state and local MCH staff are skilled with technical knowledge to complete their work. As a result of the 2015 Needs and Capacity Assessment, however, the BFH learned that many stakeholders and local and state MCH staff are not well aware of how Title V programs fit into the larger structure of services to the MCH population. Within the state Department of Health and among other state agencies, program services are often segmented in such a way that there is overlap of populations served or services rendered. In some areas, there is a great deal of collaboration between state or local agencies to assure that services are complementary and effective; however, this is not always the case. In the coming year, BFH strives to work with other state agencies or programs to improve the knowledge of staff regarding the projects being administered through Title V. As this is the beginning of the needs assessment cycle, BFH will also share with MCH stakeholders and partners the role of the Title V programs, the process used to select state priorities, and the objectives for addressing the needs of the MCH population.

In conjunction with sharing general information about programming, the BFH will identify opportunities to improve the understanding of the Life Course perspective within the MCH workforce. Multiple BFH staff have been provided with training regarding principles of the Life Course perspective, but there remains a gap in knowledge about how Life

Course theories can be implemented into practice in communities.

In addition to being familiar with services provided for the MCH population, there is a critical need within the BFH to understand how to identify and implement evidence-based or informed practices (EBP). The BFH staff has a wide variety of skills and educational background and the familiarity with EBP also varies greatly between divisions and staff. Several staff are very well accustomed to implementing EBP because of their academic training or specific programs they are working on for either Title V or other federally funded projects. Many program administrators do not have experience with implementing EBP or models and are similarly unfamiliar with techniques of literature reviews to identify and select effective practices to address a specific need. In preparing the state action plan, BFH has provided initial training to staff regarding EBP, and intends to continue to support staff to improve understanding of EBP at the program level in every division. The BFH is committed to adhering to the framework of the transformation of the Title V block grant and improving accountability by implementing EBP.

Similarly, there are large differences among local and state Title V staff who are familiar with collecting and using state or program data for evaluating and improving processes and outcomes. The BFH has selected a state priority to address this need, and in implementing the strategies of the priority, will provide professional development and training resources. By improving the capacity of the MCH workforce to use data to target program resources and evaluate program implementation, BFH staff believe that MCH populations will benefit and outcomes will be improved.

### **II.F.3. Family Consumer Partnership**

Family and consumer partnerships (FCP) are an essential component of improving the health status of MCH populations through the life course. The BFH recognizes the value of FCP and has established multiple means of incorporating families and consumers into the Title V decision-making process. The BFH has primarily integrated FCP for the CSHCN population, but has also taken steps to improve and assure cultural and linguistic competence for all MCH populations.

Pennsylvania's FCP are diverse and include mothers, fathers, and grandparents of CSHCN, representing many different types of disabilities. They include various racial and ethnic groups and are from urban, rural, and suburban regions. Since the BFH utilizes FCP in different capacities, the degree of engagement ranges from full-time employment to service on workgroups. FCPs who are not employed by the commonwealth or grantee are reimbursed for their travel and childcare costs, and all receive training on Title V.

The Traumatic Brain Injury (TBI) Advisory Board includes a requirement that at least one-third of all board members must be an individual with a brain injury or a family member. Although positions on the board are not compensated, the BFH provides for transportation, lodging and subsistence. In addition to the TBI Advisory Board, there are 10 MCH consumers and 40 family members of MCH consumers who are volunteers on advisory boards that represent the diversity of the MCH population.

The BFH employs a full-time Family Advisor, who conveys the family perspective for program and priority planning. As well, the participation of FCP in BFH activities informs the development of programs and policies. The Pennsylvania Medical Home Initiative (PA MHI) conducts Parent Panels twice annually and the Family Advisor regularly attends events geared towards families and consumers. The Special Kids Network (SKN) facilitates Family Gatherings, SKN Meetings, and Parent Youth Professional Forums to hear issues that are impacting the MCH population. In order to improve access to and representation for family/consumer engagement activities, the BFH has ensured that buildings and accommodations are accessible; meetings are held throughout the state to include

rural, urban and suburban settings; and interpreters or translated documents are provided when needed.

The Department convened a Cultural and Linguistic Competence Stakeholders Group, comprised of advocates, families and professionals. This group is in the process of implementing an action plan that they developed that details how to promote and assure the provision of culturally and linguistically competent services for all families. A Core Leadership Team was established at a statewide level consisting of parents, youth and professionals as well as Department representatives from the BFH to provide information and direction for action and to ensure that cultural and linguistic competence is embedded in all components of services. Both the Stakeholders group and Core Leadership Team include families and consumers as participants and contributors.

In December 2014, the Department endorsed and adopted the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS). The Department expects all staff, grantees, stakeholders, contractors or service providers, outreach initiatives, health services, and health care practices (particularly those that receive federal funding) to adhere to and follow these principles and standards in the pursuit of advancing health equity, improving quality and helping to eliminate health care disparities in Pennsylvania. The adoption of CLAS means that all members of an organization, regardless of the number of members, are encouraged to apply them at every point of contact. CLAS are focused on treating individuals with respect and in accordance with their culture and language.

The MHI also engages Parent Advisors, an Education Specialist, a youth as a Social Media Intern, and a youth on the Advisory Committee. The SKN employs parents of CSHCN as Regional Coordinators (RC) and a Regional Coordinator Supervisor.

The BFH welcomes input from families and consumers about the development of block grant activities. The TBI Advisory Board, as well as other stakeholder groups and advisory committees, participated in Focus Groups to assist in the selection of priorities for the Block Grant over the next five years. FCP have been offered opportunities to provide feedback on the development of the state action plan for the block grant.

Communications, products and educational materials are reviewed to assure that they are written at an appropriate reading level. The Core Leadership Team is working to ensure that cultural and linguistic competence is embedded in all components of services, including forms, pamphlets, and fact sheets.

The PA Medical Home Initiative (PA MHI) has steadily increased the numbers of families and consumers who serve as Parent Partners to assist with planning and advocacy at the community level.

The Family Advisor regularly attends events geared towards families and consumers, and works with programs funded through Title V and with other programs. The BFH partners with the state's Family to Family provider; other parent education/advocacy groups, and state agencies serving the MCH population.

BFH includes language in vendor contracts to assure that each vendor is directed to make specific efforts to work with local community organizations to identify and reach underserved populations located within their service area.

#### **II.F.4. Health Reform**

The implementation of the Affordable Care Act (ACA) in Pennsylvania has evolved since the initial passage of the federal legislation. Pennsylvania did not set up a state-based marketplace and is currently participating in the federal health plan marketplace. As of February, 2015, over 470,000 consumers selected or were automatically re-enrolled

in coverage through the marketplace; 40 percent of which were new enrollees. Since the marketplace's first open enrollment period, almost 108,000 individuals have gained CHIP or Medicaid coverage, with children accounting for over half the enrollment as of January 2015.

In 2014, former Governor Corbett implemented the Medicaid expansion through a waiver as opposed to launching the expansion on January 1, 2014. Coverage under the waiver became effective on January 1, 2015; however, newly elected Governor Wolf withdrew the waiver and is implementing a traditional Medicaid expansion called Health Choices. Implementation of Health Choices is anticipated to begin by September 30, 2015. The expansion of Medicaid is expected to result in an estimated \$16.5 billion in additional Medicaid federal funds from 2014-2020 and is projected to lead to additional billions in economic activity.

During the years since the implementation of the Affordable Care Act (ACA), the BFH has examined the structure of Title V programming in order to support the goals of the ACA and prevent duplicating services or payments. To support the health reform efforts and reduce duplication of services, BFH has initiated conversations with the Department of Human Services to identify benefits that are covered by Medical Assistance or CHIP health plans for MCH populations. BFH is committed to providing safety net services for vulnerable populations who are unable to access the services they need through traditional payment mechanisms. However, BFH plans to closely monitor programming to assure that direct services are funded as a last resort. By working at both the population level and the public health systems level to increase access and decrease barriers to healthcare, BFH intends to support MCH populations to obtain services they need during critical life stages.

Direct services are provided by local Title V agencies for children and pregnant women who are uninsured, underinsured, or uninsurable. Services include early pregnancy testing to encourage early entry into prenatal care or home visiting programs and depression screenings to all prenatal and postpartum women receiving services. Referrals are provided as needed to improve the health of women and their families.

Direct services are also targeted for specific community needs in other areas of the state. The Allentown City Bureau of Health, Montgomery County Health Department (MCHD) and the Wilkes-Barre City Health Department provide dental services to children, through the age of 21, who are uninsured, underinsured or uninsurable. Essential services such as routine examinations, cleanings, extractions and fillings are combined with education related to oral health care. Erie County Health Department and the Philadelphia Department of Public Health (PDPH) offer health clinics to individuals who have no insurance due to a gap in coverage between providers or insurances or for individuals who are uninsurable. Basic health services such as well visits, immunizations, referral services etc., are provided to offer a safety-net for the Title V population. MCHD, PDPH, Albert Einstein Hospital Network (AEHN) and Lancaster General Hospital (LGH) offer prenatal services. MCHD and PDPH provide prenatal care to uninsurable women who would not otherwise be able to afford prenatal care throughout their pregnancy. AEHN and LGH offer prenatal care through Centering Pregnancy programs. The Division of Newborn Screening and Genetics provides safety net pharmaceutical services for patients with medical confirmation of Cystic Fibrosis. To be eligible for services, patients meet all of the following criteria: U.S. citizenship, Pennsylvania residency, lack of monetary resources or health insurance. Depending on income, some families may be required to contribute to the cost of their prescriptions. If the eligible individual has prescription coverage, it must be used first.

Many adolescents avoid needed healthcare because they are insured under their parents' health plans and concerned about their parents' reactions if they obtain sexual or reproductive health services. To overcome this barrier, BFH works with local providers for the adolescent health programs described below to provide confidential services. Title V is the payor of last resort for all programs.

Four family planning councils provide reproductive health services to youth 17 and younger. Services provided include: routine gynecological care, pregnancy testing, contraceptives, cervical cancer screening tests, screening and treatment for sexually transmitted diseases, education and counseling, and general health screening services.

AccessMatters provides reproductive health services to high school students through the Health Resource Center (HRC) program. Reproductive health services include: counseling and education around abstinence, health, decision making and sexuality, availability of safer sex materials, and referrals to school and community-based resources inclusive of sexual and reproductive health care. AccessMatters operates HRCs in nine Philadelphia area schools.

The Mazzone Center provides a drop-in clinic for LGBTQ youth in Philadelphia. Mazzone Center provides primary medical care, support services including case management, HIV and sexually transmitted disease testing and screening, and health education regardless of insurance status.

In the coming year, BFH will identify strategies to improve health literacy of MCH populations in order to improve access to health insurance and preventive services. BFH staff are collaborating with the Bureau of Health Promotion and Risk Reduction by participating in the Health Literacy Coalition, an initiative that spreads awareness and builds capacity to foster the identification, sharing, and spreading of best practices in creating and sustaining health literate organizations and communities.

Dr. Karen M. Murphy, PhD., RN, Secretary of Health, is establishing a Center for Health Innovation, with a vision of revamping the structure and strategies that the Department engages to promote and protect health. The goals of Health Innovation are to identify new ideas to deliver better health, improved care, and lower costs to people, especially those with the highest healthcare needs. The Health Innovation structure will be comprised of a Population Health office that identifies public-private partnerships and intra-agency efforts. The Population Health office will include an epidemiologist, data analytics staff, health economist, and quality improvement staff, as well as a grant writer and staff to examine delivery and payment models. The Department will develop a State Health Innovation Plan, based on five pillars of health innovation: population health, healthcare delivery, workforce, health information technology, and payment reform. To achieve the goals of Health Innovation, the Department will engage stakeholders to participate on a steering committee and regional workgroups for each of the five pillars. BFH anticipates that the Health Innovation efforts by the Department will inform and impact strategies for the delivery of Title V services.

#### **II.F.5. Emerging Issues**

As is the case in many states, Pennsylvania is facing an epidemic of prescription drug misuse and abuse and heroin use. Based on recently released CDC data, the greatest increases in heroin use have been in demographic groups that have not historically been the highest risk, including females, 18-25 year olds, non-Hispanic whites, and privately insured people. However, nearly all demographics have shown an increase in heroin use and heroin-related overdose deaths. Heroin addiction is closely linked to addictions to prescription opioid painkillers, which is also increasing rapidly. These issues are not confined to the MCH population, but have implications across the life course. The PA Department of Drug and Alcohol Programs and Department of Health have initiatives underway to monitor opioid prescribing practices, prevent prescription drug abuse, and reverse the trend of overdose deaths. The BFH has incorporated behavioral health screenings and referrals as part of the action plan, and will follow the direction of the Department to adapt the state action plan as needed in future years.

Another emerging issue in Pennsylvania is the use of hydraulic fracturing, or “fracking” for natural gas drilling wells in

northeast and southwest regions of Pennsylvania. There are over 7,500 active natural gas wells in Pennsylvania and conflicting studies about the impact of fracking on human health. A recent study compared eight counties that account for the majority of gas wells in Pennsylvania and compared health measures to the rest of the state and to the same areas before fracking began. In this study, the heavily-fracked counties show greater rates of infant mortality, perinatal mortality, low-weight births, and premature births/gestation less than 32 weeks.

There are still many research gaps in understanding the health implications of fracking. The Department of Environmental Protection regulates natural gas drills and the Department of Health's Bureau of Epidemiology has a process in place to receive, respond to, and catalogue individual health inquiries related to environmental concerns. The BFH has not included any objectives or strategies to address health concerns for MCH populations related to fracking, but will promote and adhere to recommendations developed by the Bureau of Epidemiology.

The Bureau of Health Promotion and Risk Reduction (BHPRR) is leading DOH's effort to plan and develop strategies for building statewide infrastructure to support Community Health Workers (CHW). While use of CHW have proven to be cost-effective means of improving specific health outcomes in some cities or communities, there has not been a statewide approach to implement consistent practices. DOH is in the process of developing standard definitions, training requirements, and a scope of practice in order to build capacity, research and evaluate outcomes and seek sustainable funding. BFH is supporting the efforts of BHPRR but has not specifically incorporated objectives or strategies into the action plan at this time. Based on further evaluation of opportunities for CHW to address MCH population needs, the BFH may explore the feasibility of using CHW as partners in the Title V workforce.

When working with families across the state to assist in the coordination of necessary services, several types of unmet needs are frequently raised and one of those issues is the lack of accessible, affordable mental health services. The BFH has implemented screening programs for mental and behavioral health issues but has not previously addressed the availability of mental health services. Currently, through a joint effort with the Department of Human Services, the BFH is implementing Project LAUNCH in Allegheny County, to develop a public health approach of coordinated programs and services to address physical, emotional, social, and behavioral health. For many, both parents and providers, there was a lack of awareness that these issues could be present in young children. This presented a challenge to agencies and community organizations who knew that a comprehensive, seamless system that promoted both physical and behavioral health was needed. Since the notice of award in September of 2014, an environmental scan, strategic plan, and evaluation plan have been developed. Issues including the lack of accessibility, timely intervention, payment, and transportation to appointments were identified during the process. The implementation team developed for the grant is currently working to identify evidence-based screening tools and methods to conduct workforce development so support services for children with mental health issues will be available when needed.

#### **II.F.6. Public Input**

Based upon prior feedback regarding greater public involvement during the development of the needs assessment and Application/Annual report, the Bureau of Family Health (BFH) took deliberate steps to incorporate public involvement earlier in the process leading up to the Application/Annual Report.

As part of the needs assessment process, public input was solicited in several ways. A request for public comment on the State Health Assessment was made via the Department of Health (DOH) website, in the DOH Health Statistics Bulletin and via distribution to Advisory Committee members and Health Improvement partners. A dedicated email was created to receive feedback. All feedback was requested between Sept. 3-27, 2013; a total of

18 comments were received.

Stakeholder focus groups facilitated by the BFH staff were also conducted from Nov. 7 to Dec. 18, 2014 as part of the needs assessment. Responses to the focus group questions were organized into themes by domain and re-sent to the stakeholders along with the NPMs via email with a request for additional comments and input regarding evidence-based strategies. Stakeholders had from March 16-April 3, 2015 to provide feedback. The BFH received thirteen responses to this request, many recommending evidence-based strategies for a broad range of issues. The BFH will continue to reference this material as the State Action Plan is finalized over the next year.

After an internal review and compilation of state priorities, BFH disseminated a draft of the priorities to current grantees and stakeholders during meetings and by email. BFH staff provided explanations of the process to select priorities and solicited comments from the public regarding the selected priorities; no formal written comments were received.

Upon completion of the Application/Annual Report, the BFH will post the document to the Title V website and notify the stakeholder groups of its location. An announcement of the submission of the Application/Annual Report will also be published in the PA Bulletin with a link to the website location.

Following submission of the Application/Annual Report, the BFH will update the Title V website with the new priorities and performance measures. The interim action plan will be posted on the website as well. The BFH will strive to have a greater online presence and encourage more public input throughout the reporting year. The BFH will secure a dedicated email address, available on the website, through which people can submit comments, concerns or questions regarding any of the Title V related documents as a first step in this process. Over the course of the grant cycle, the BFH will work with the Bureau of Health Statistics and Research to develop survey tools to use for both consumer and stakeholder feedback for future Applications/Annual Reports.

#### **II.F.7. Technical Assistance**

At this time the Bureau of Family Health does not anticipate any need for technical assistance.

### III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$ 24,121,972	\$ 23,930,277	\$ 24,147,277	\$ 22,764,692
<b>Unobligated Balance</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>State Funds</b>	\$ 57,670,000	\$ 56,294,988	\$ 57,474,000	\$ 56,120,332
<b>Local Funds</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>Other Funds</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>Program Funds</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>SubTotal</b>	\$ 81,791,972	\$ 80,225,265	\$ 81,621,277	\$ 78,885,024
<b>Other Federal Funds</b>	\$ 229,374,039	\$ 233,264,882	\$ 234,180,272	\$ 187,953,009
<b>Total</b>	\$ 311,166,011	\$ 313,490,147	\$ 315,801,549	\$ 266,838,033

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$ 24,147,277	\$ 23,442,305	\$ 23,296,703	\$
<b>Unobligated Balance</b>	\$ 0	\$ 0	\$ 0	\$
<b>State Funds</b>	\$ 57,775,000	\$ 44,636,906	\$ 57,510,000	\$
<b>Local Funds</b>	\$ 0	\$ 0	\$ 0	\$
<b>Other Funds</b>	\$ 0	\$ 0	\$ 0	\$
<b>Program Funds</b>	\$ 0	\$ 0	\$ 0	\$
<b>SubTotal</b>	\$ 81,922,277	\$ 68,079,211	\$ 80,806,703	\$
<b>Other Federal Funds</b>	\$ 214,421,400		\$ 226,007,691	\$
<b>Total</b>	\$ 296,343,677	\$ 68,079,211	\$ 306,814,394	\$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
<b>Federal Allocation</b>	\$ 23,442,305	\$
<b>Unobligated Balance</b>	\$ 0	\$
<b>State Funds</b>	\$ 47,298,000	\$
<b>Local Funds</b>	\$ 0	\$
<b>Other Funds</b>	\$ 0	\$
<b>Program Funds</b>	\$ 0	\$
<b>SubTotal</b>	\$ 70,740,305	\$
<b>Other Federal Funds</b>	\$ 4,350,997	\$
<b>Total</b>	\$ 75,091,302	\$

### III.A. Expenditures

Form 2 (MCH Budget/Expenditure Details), Form 3a (Budget and Expenditure Details by Types of Individuals Served), and Form 3b (Budget and Expenditure Details by Types of Services) have been completed in accordance with the guidance. All direct service expenditures reported on form 3b reflect services that were not covered or reimbursed through another provider. Title V is the payer of last resort for all direct services.

Expenditures of Title V funds are in compliance with the legislative requirements that a minimum of 30 percent of funds are allocated for the support of preventive and primary services for children; a minimum of 30 percent of funds are allocated for services for children with special health care needs; and a maximum of 10 percent of funds are allocated as administrative costs. Administrative costs in 2014 were less than 10 percent, due to personnel vacancies during the project period and lower than anticipated Administrative costs.

The total state funds budgeted in 2014 included state funding for the Chronic Renal Disease Program (CRDP) and the Head Injury Program (HIP). Both of these state-funded programs are administered in the Bureau of Family Health (BFH) and have previously been included in the total state funds under the control of the Title V agency. Beginning in this reporting year, BFH is omitting the CRDP and HIP expenditures as the programs do not provide services for MCH populations. Therefore, there is a significant discrepancy between the amount of non-federal funds budgeted for 2014 and the expenditures for 2014. All non-federal funds reported provide services for MCH populations.

### III.B. Budget

Form 2 (MCH Budget/Expenditure Details), Form 3a (Budget and Expenditure Details by Types of Individuals Served), and Form 3b (Budget and Expenditure Details by Types of Services) have been completed in accordance with the guidance. Pennsylvania is requesting a federal funding amount for FFY 2016 that is level with the FFY2014 award.

Pennsylvania's proposed budget for FFY 2016 is in full compliance with the federally mandated threshold requirements. Of Pennsylvania's proposed federal grant award for 2016, \$12,616,373 (53.8% of the total budget) is designated for the support of preventive and primary services for children, and \$8,481,702 (36.2% of total budget) is designated for the support of services for children with special health care needs. Administrative costs are budgeted at \$2,344,230, which is 10 percent of the grant award. Administrative Costs include all personnel and operating costs that are not directly or indirectly incurred for the provision of prevention, education, intervention, or treatment services.

Pennsylvania bases maintenance of effort match funds on all non-federal funds that exclusively serve MCH populations. Pennsylvania's maintenance of effort amount from 1989 is \$20,065,575. Non-federal funds that contribute to the maintenance of effort amount include state appropriations for School Health Services, and Maternal and Child Health Services. Additional state funds that are under the control of the BFH and serve the MCH population include appropriations for special conditions such as Sickle Cell, Cystic Fibrosis, Hemophilia, Cooley's Anemia, Tourette Syndrome, Services for Children with Special Needs, Epilepsy, and Newborn Screening. Total state funds contributed to the MCH services in 2016 are \$47,298,000. The total state funds budgeted for 2016 do not include funding for the Chronic Renal Disease Program (CRDP) and the Head Injury Program (HIP), which were both previously included in the total state funds under the control of the Title V agency. Beginning in this reporting year, BFH is omitting the CRDP and HIP expenditures as the programs do not provide services for the MCH population.

The BFH is the recipient of several other federally funded projects that impact the MCH population, including: Abstinence Education Grant and Personal Responsibility Education Program from the Administration for Children and Families; Pregnancy Risk Assessment Monitoring System from CDC; State Systems Development Initiative, Traumatic Brain Injury, and Universal Newborn Hearing Screening and Intervention from HRSA; and Lead Abatement from the Environmental Protection Agency. The total funding from all other federal projects for 2016 is \$4,350,997.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [MOU.pdf](#)

## V. Supporting Documents

No Supporting documents were provided by the state.

## VI. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

**State: Pennsylvania**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>1. FEDERAL ALLOCATION</b>	\$ 23,442,305	\$ 23,442,305
<i>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)</i>		
A. Preventive and Primary Care for Children	\$ 12,616,373	\$ 12,546,063
B. Children with Special Health Care Needs	\$ 8,481,702	\$ 9,306,423
C. Title V Administrative Costs	\$ 2,344,230	\$ 1,589,818
<b>2. UNOBLIGATED BALANCE</b>	\$ 0	\$ 0
<i>(Item 18b of SF-424)</i>		
<b>3. STATE MCH FUNDS</b>	\$ 47,298,000	\$ 44,636,906
<i>(Item 18c of SF-424)</i>		
<b>4. LOCAL MCH FUNDS</b>	\$ 0	\$ 0
<i>(Item 18d of SF-424)</i>		
<b>5. OTHER FUNDS</b>	\$ 0	\$ 0
<i>(Item 18e of SF-424)</i>		
<b>6. PROGRAM INCOME</b>	\$ 0	\$ 0
<i>(Item 18f of SF-424)</i>		
<b>7. TOTAL STATE MATCH</b>	\$ 47,298,000	\$ 44,636,906
<i>(Lines 3 through 6)</i>		
A. Your State's FY 1989 Maintenance of Effort Amount	\$ 20,065,575	
<b>8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL</b>	\$ 70,740,305	\$ 68,079,211
<i>(Same as item 18g of SF-424)</i>		
<b>9. OTHER FEDERAL FUNDS</b>		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
<b>10. OTHER FEDERAL FUNDS</b>	\$ 4,350,997	
<i>(Subtotal of all funds under item 9)</i>		
<b>11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL</b>	\$ 75,091,302	\$ 68,079,211
<i>(Partnership Subtotal + Other Federal MCH Funds Subtotal)</i>		

**FY14 Annual Report Budgeted**

<b>1. FEDERAL ALLOCATION</b>	\$ 24,147,277
A. Preventive and Primary Care for Children	\$ 12,776,006
B. Children with Special Health Care Needs	\$ 8,956,544
C. Title V Administrative Costs	\$ 2,414,727
<b>2. UNOBLIGATED BALANCE</b>	<b>\$ 0</b>
<b>3. STATE MCH FUNDS</b>	<b>\$ 57,775,000</b>
<b>4. LOCAL MCH FUNDS</b>	<b>\$ 0</b>
<b>5. OTHER FUNDS</b>	<b>\$ 0</b>
<b>6. PROGRAM INCOME</b>	<b>\$ 0</b>
<b>7. TOTAL STATE MATCH</b>	<b>\$ 57,775,000</b>

**FY16 Application  
Budgeted**

**9. OTHER FEDERAL FUNDS**

Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program;	\$ 1,552,455
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP);	\$ 1,979,932
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS);	\$ 134,828
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI);	\$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury;	\$ 241,630
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention;	\$ 250,000
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Lead Abatement;	\$ 96,778

**Form Notes For Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs:</b>
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	<b>Fiscal Year:</b>	<b>2014</b>
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	<b>Column Name:</b>	<b>Annual Report Expended</b>
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**Field Note:**

The agency expended less than 10% of the total award on administrative costs during FY14.

2.	<b>Field Name:</b>	<b>3. STATE MCH FUNDS</b>
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	<b>Fiscal Year:</b>	<b>2014</b>
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	<b>Column Name:</b>	<b>Annual Report Expended</b>
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**Field Note:**

FY16 budgeted amounts are based on total allocations. FY 14 annual report expended amounts are actual expenditures, which were less than the full allocation. The total state funds budgeted in 2014 included state funding for the Chronic Renal Disease Program (CRDP) and the Head Injury Program (HIP). Beginning with 2014 reporting, BFH is omitting the CRDP and HIP expenditures as the programs do not provide services for MCH populations

**Data Alerts:**

None

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: Pennsylvania**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>I. TYPES OF INDIVIDUALS SERVED</b>		
<b>IA. Federal MCH Block Grant</b>		
1. Pregnant Women	\$ 2,258,971	\$ 1,979,595
2. Infants < 1 year	\$ 2,360,228	\$ 2,045,124
3. Children 1-22 years	\$ 7,860,226	\$ 8,425,053
4. CSHCN	\$ 8,412,649	\$ 9,183,355
5. All Others	\$ 206,000	\$ 219,359
<b>Federal Total of Individuals Served</b>	<b>\$ 21,098,074</b>	<b>\$ 21,852,486</b>
<b>IB. Non Federal MCH Block Grant</b>		
1. Pregnant Women	\$ 0	\$ 0
2. Infants < 1 year	\$ 6,284,400	\$ 4,117,991
3. Children 1-22 years	\$ 36,620,000	\$ 35,454,637
4. CSHCN	\$ 2,550,665	\$ 2,742,399
5. All Others	\$ 1,842,935	\$ 2,321,879
<b>Federal Total of Individuals Served</b>	<b>\$ 47,298,000</b>	<b>\$ 44,636,906</b>
<b>Federal State MCH Block Grant Partnership Total</b>	<b>\$ 68,396,074</b>	<b>\$ 66,489,392</b>

**Form Notes For Form 3a:**

None

**Field Level Notes for Form 3a:**

1.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1-22 years</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	Pennsylvania considers services provided during the prenatal and infancy periods as Preventive and Primary Care for Children, as the ultimate outcome of the service is to contribute to a healthy childhood. The costs reported by types of individuals served (form 3a), are categorized by the status of the individual at the time they received the service.
2.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 4. CSHCN</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	Services for Children with Special Health Care Needs reported on Form 2, line 1B includes infrastructure and services for families of CSHCN. Form 3a is limited to the services provided directly to CSHCN individuals.
3.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1-22 years</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Pennsylvania considers services provided during the prenatal and infancy periods as Preventive and Primary Care for Children, as the ultimate outcome of the service is to contribute to a healthy childhood. The costs reported by types of individuals served (form 3a), are categorized by the status of the individual at the time they receive the service.
4.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 4. CSHCN</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Services for Children with Special Health Care Needs reported on Form 2, line 1B includes infrastructure and services for families of CSHCN. Form 3a is limited to the services provided directly to CSHCN individuals.

**Data Alerts:**

None

**Form 3b**  
**Budget and Expenditure Details by Types of Services**  
**State: Pennsylvania**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>I. TYPES OF SERVICES</b>		
<b>IIA. Federal MCH Block Grant</b>		
1. Direct Services	\$ 3,984,000	\$ 3,997,528
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 1,197,500	\$ 1,190,282
B. Preventive and Primary Care Services for Children	\$ 2,200,000	\$ 2,085,105
C. Services for CSHCN	\$ 586,500	\$ 722,141
2. Enabling Services	\$ 4,144,848	\$ 3,648,057
3. Public Health Services and Systems	\$ 15,313,457	\$ 15,796,720
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 645,867
Physician/Office Services		\$ 3,270,591
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 81,070
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Direct Services Total		\$ 3,997,528
<b>Federal Total</b>	<b>\$ 23,442,305</b>	<b>\$ 23,442,305</b>

**IIB. Non-Federal MCH Block Grant**

1. Direct Services	\$ 6,428,000	\$ 4,239,455
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 6,284,400	\$ 4,117,991
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 143,600	\$ 121,464
2. Enabling Services	\$ 0	\$ 699,964
3. Public Health Services and Systems	\$ 40,870,000	\$ 39,697,487
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 847,891
Physician/Office Services		\$ 726,427
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		\$ 2,665,137
Direct Services Total		\$ 4,239,455
<b>Non-Federal Total</b>	<b>\$ 47,298,000</b>	<b>\$ 44,636,906</b>

**Form Notes For Form 3b:**

None

**Field Level Notes for Form 3b:**

None

**Form 4**  
**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**  
**State: Pennsylvania**

**Total Births by Occurrence**

141,770

**1a. Core RUSP Conditions**

<b>Program Name</b>	<b>(A) Number Receiving at Least One Screen</b>	<b>(B) Number Presumptive Positive Screens</b>	<b>(C) Number Confirmed Cases</b>	<b>(D) Number Referred for Treatment</b>
Propionic acidemia	139,803 (98.6%)	9	1	1 (100.0%)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	139,803 (98.6%)	9	0	0 (0%)
Methylmalonic acidemia (cobalamin disorders)	139,803 (98.6%)	9	0	0 (0%)
Isovaleric acidemia	139,803 (98.6%)	0	0	0 (0%)
3-Methylcrotonyl-CoA carboxylase deficiency	139,803 (98.6%)	7	5	5 (100.0%)
3-Hydroxy-3-methylglutaric aciduria	139,803 (98.6%)	7	0	0 (0%)
Holocarboxylase synthase deficiency	139,803 (98.6%)	0	0	0 (0%)
β-Ketothiolase deficiency	139,803 (98.6%)	7	0	0 (0%)
Glutaric acidemia type I	139,803 (98.6%)	5	4	4 (100.0%)
Carnitine uptake defect/carnitine transport defect	139,803 (98.6%)	0	0	0 (0%)
Medium-chain acyl-CoA dehydrogenase deficiency	139,826 (98.6%)	8	6	6 (100.0%)
Very long-chain acyl-CoA dehydrogenase deficiency	139,803 (98.6%)	1	1	1 (100.0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	139,803 (98.6%)	0	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Trifunctional protein deficiency	139,803 (98.6%)	0	0	0 (0%)
Argininosuccinic aciduria	139,800 (98.6%)	0	0	0 (0%)
Citrullinemia, type I	139,800 (98.6%)	1	1	1 (100.0%)
Maple syrup urine disease	140,045 (98.8%)	7	1	1 (100.0%)
Homocystinuria	139,801 (98.6%)	9	0	0 (0%)
Classic phenylketonuria	141,048 (99.5%)	16	6	6 (100.0%)
Tyrosinemia, type I	139,800 (98.6%)	4	0	0 (0%)
Primary congenital hypothyroidism	139,670 (98.5%)	79	52	52 (100.0%)
Congenital adrenal hyperplasia	141,001 (99.5%)	68	8	8 (100.0%)
S,S disease (Sickle cell anemia)	141,006 (99.5%)	27	27	27 (100.0%)
S, $\beta$ -thalassemia	141,006 (99.5%)	2	2	2 (100.0%)
S,C disease	141,006 (99.5%)	23	23	23 (100.0%)
Biotinidase deficiency	139,822 (98.6%)	32	27	27 (100.0%)
Critical congenital heart disease	113,201 (79.8%)	50	3	3 (100.0%)
Cystic fibrosis	140,224 (98.9%)	214	36	36 (100.0%)
Hearing loss	137,533 (97.0%)	740	196	196 (100.0%)
Severe combined immunodeficiencies	105,657 (74.5%)	16	3	3 (100.0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Classic galactosemia	141,006 (99.5%)	26	5	5 (100.0%)

**1b. Secondary RUSP Conditions**

**2. Other Newborn Screening Tests**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	137,533 (97.0%)	740	196	196 (100.0%)

**3. Screening Programs for Older Children & Women**

**4. Long-Term Follow-Up**

In Pennsylvania, the Bureau of Family Health (BFH) provides follow-up after initial presumptive positive screens are received, to assure that infants are referred to treatment centers or specialists for confirmatory testing. After a diagnosis is made by the treatment center or specialist, BFH closes the case and does not provide additional follow-up.

**Form Notes For Form 4:**

Data source: PA Department of Health, Division of Newborn Screening & Genetics

**Field Level Notes for Form 4:**

None

**Form 5a**  
**Unduplicated Count of Individuals Served under Title V**  
**State: Pennsylvania**  
**Reporting Year 2014**

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	4,093	41.0	0.1	4.6	28.7	25.6
2. Infants < 1 Year of Age	142,949	0.4	0.0	0.0	0.0	99.6
3. Children 1 to 22 Years of Age	32,978	46.1	0.1	0.1	3.3	50.4
4. Children with Special Health Care Needs	54,859	36.9	0.0	30.8	0.6	31.7
5. Others	40,198	2.4	0.0	2.7	0.2	94.7
<b>Total</b>	<b>275,077</b>					

**Form Notes For Form 5a:**

The Bureau does not have a capability to unduplicate numbers between the various divisions or their programs. Three divisions within the Bureau of Family Health have broad Title V responsibilities and each serves multiple categories within the "Types of Individuals Served." The Total Served is the sum of each of the division's "Total" for each of the categories. The data collection and tracking capabilities vary depending on the type of service/program within each Division and come from multiple projects and different sources.

**Field Level Notes for Form 5a:**

None

**Form 5b**  
**Total Recipient Count of Individuals Served by Title V**  
**State: Pennsylvania**  
**Reporting Year 2014**

<b>Types Of Individuals Served</b>	<b>Total Served</b>
1. Pregnant Women	4,093
2. Infants < 1 Year of Age	142,949
3. Children 1 to 22 Years of Age	42,656
4. Children with Special Health Care Needs	54,860
5. Others	40,643
<b>Total</b>	<b>285,201</b>

**Form Notes For Form 5b:**

The Bureau does not have a capability to unduplicate numbers between the various divisions or their programs. Three divisions within the Bureau of Family Health have broad Title V responsibilities and each serves multiple categories within the "Types of Individuals Served." The Total Served is the sum of each of the division's "Total" for each of the categories for services within the top two service levels of the MCH Pyramid. The data collection and tracking capabilities vary depending on the type of service/program within each Division and come from multiple projects and different sources.

**Field Level Notes for Form 5b:**

None

**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**  
**State: Pennsylvania**  
**Reporting Year 2014**

**I. Unduplicated Count by Race**

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	138,612	98,260	19,866	127	5,535	117	3,814	10,893
Title V Served	3,444	1,672	840	18	161	5	65	683
Eligible for Title XIX	57,018	31,051	15,672	83	1,676	44	0	8,492
2. Total Infants in State	142,949	108,812	20,002	0	6,006	0	7,411	718
Title V Served	575	303	180	3	29	2	20	38
Eligible for Title XIX	158,552	88,377	40,647	223	4,252	78	0	24,975

**II. Unduplicated Count by Ethnicity**

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	123,426	14,018	1,168	138,612
Title V Served	2,046	76	1,322	3,444
Eligible for Title XIX	47,813	9,205	0	57,018
2. Total Infants in State	129,047	13,902	0	142,949
Title V Served	395	17	163	575
Eligible for Title XIX	134,459	24,093	0	158,552

**Form Notes For Form 6:**

Form 6 requires information from the PA DOH, Bureau of Health Statistics and Research, and the PA DHS, Office of Medical Assistance Programs, both of which are generally only available after a one-year delay, and other program information, which is generally available fairly close to the end of the year in question. In an effort to make our reporting as current as possible, and for the convenience of the disparate program personnel who supply us with data, Form 6 reflects data from reporting periods described below. Total Deliveries in State and Total Infants in State are based on preliminary 2013 data. Title V Served is 2014 program data. Title V served for deliveries is number of pregnant and postpartum women served by PA's local Title V agencies. Title V served for infants is also number of infants served by PA's local Title V agencies Eligible for Title XIX is final 2013 data for the Pennsylvania Medical Assistance deliveries and infants.

**Field Level Notes for Form 6:**

1.	<b>Field Name:</b>	<b>1. Total Deliveries in State</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Source: PA Department of Health, Division of Health Informatics, Certificates of Birth
2.	<b>Field Name:</b>	<b>2. Total Infants in State</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Source: Pennsylvania State Data Center. Data for Native Hawaiian or Other Pacific Islander infants is combined with Asian infants. There is no count available for American Indian or Native Alaskan as PaSDC combines these into the Other category.

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**

**State: Pennsylvania**

**Application Year 2016**

**Reporting Year 2014**

**A. State MCH Toll-Free Telephone Lines**

1. State MCH Toll-Free "Hotline" Telephone Number	(800) 986-2229	(800) 986-2229
2. State MCH Toll-Free "Hotline" Name	Healthy Baby	Healthy Baby
3. Name of Contact Person for State MCH "Hotline"	Amy Rothenberger	Amy Rothenberger
4. Contact Person's Telephone Number	(717) 772-2763	(717) 772-2763
5. Number of Calls Received on the State MCH "Hotline"		498

**B. Other Appropriate Methods**

1. Other Toll-Free "Hotline" Names	Special Kids Network	Special Kids Network
2. Number of Calls on Other Toll-Free "Hotlines"		1,248
3. State Title V Program Website Address	<a href="http://www.health.pa.gov/Your-Department-of-Health/Administrative/Title%20V%20Funds/Pages/default.aspx#.VaQVC5jD-Uk">http://www.health.pa.gov/Your-Department-of-Health/Administrative/Title%20V%20Funds/Pages/default.aspx#.VaQVC5jD-Uk</a>	<a href="http://www.health.pa.gov/Your-Department-of-Health/Administrative/Title%20V%20Funds/Pages/default.aspx#.VaQVC5jD-Uk">http://www.health.pa.gov/Your-Department-of-Health/Administrative/Title%20V%20Funds/Pages/default.aspx#.VaQVC5jD-Uk</a>
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites	facebook.com/pennsylvania departmentofhealth; twitter.com/padepthofhealth	
6. Number of Hits to the State Title V Program Social Media Websites		

**Form Notes For Form 7:**

The Bureau is not able to collect the number of hits for program websites, therefore this number is reported as 0.

**Form 8**  
**State MCH and CSHCN Directors Contact Information**

**State: Pennsylvania**

**Application Year 2016**

**1. Title V Maternal and Child Health (MCH)  
Director**

Name	Carolyn Cass
Title	Director, Bureau of Family Health
Address 1	625 Forster Street, Health and Welfare Building
Address 2	7th Floor East
City / State / Zip Code	Harrisburg / PA / 17120
Telephone	(717) 346-3000
Email	ccass@pa.gov

**2. Title V Children with Special Health Care  
Needs (CSHCN) Director**

Name	Michelle Connors
Title	Director, Div of Community Systems Dev and Outreach
Address 1	625 Forster Street, Health and Welfare Building
Address 2	7th Floor East
City / State / Zip Code	Harrisburg / PA / 17120
Telephone	(717) 346-3000
Email	mconnors@pa.gov

**3. State Family or Youth Leader (Optional)**

Name	
Title	
Address 1	
Address 2	
City / State / Zip Code	
Telephone	
Email	

**Form Notes For Form 8:**

None

**Form 9  
List of MCH Priority Needs**

**State: Pennsylvania**

**Application Year 2016**

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	MCH populations reside in a safe and healthy living environment.	Replaced	
2.	Appropriate health and health related services, screenings and information are available to the MCH populations.	Replaced	
3.	MCH populations are able to obtain, process and understand basic health information needed to make health decisions.	New	
4.	Protective factors are established for adolescents and young adults prior to and during critical life stages.	Replaced	
5.	Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants.	New	
6.	Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.	Replaced	
7.	Safe sleep practices are consistently implemented for all infants.	New	
8.	Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.	New	This priority will supplement the capacity to achieve all other priorities using data driven decisions to support evidence based measures.
9.	Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.	Replaced	



**Form Notes For Form 9:**

None

**Field Level Notes for Form 9:**

**Field Name:**

Priority Need 1

**Field Note:**

**Field Name:**

Priority Need 2

**Field Note:**

A state performance measure is being developed for this priority.

**Field Name:**

Priority Need 3

**Field Note:**

A state performance measure is being developed for this priority.

**Field Name:**

Priority Need 4

**Field Note:**

**Field Name:**

Priority Need 5

**Field Note:**

**Field Name:**

Priority Need 6

**Field Note:**

**Field Name:**

Priority Need 7

**Field Note:**

**Field Name:**

Priority Need 8

**Field Note:**

**Field Name:**

Priority Need 9

**Field Note:**

**Field Name:**

Priority Need 10

**Field Note:**

**Form 10a**  
**National Outcome Measures (NOMs)**  
**State: Pennsylvania**

**Form Notes for Form 10a NPMs and NOMs:**

The data provided in the annual objectives for NPM 11 are for children with special health care needs. For nonCSHCN the following data are provided: 2016-61.8 2017-62.0 2018-62.2 2019-62.4 2020-62.6 Data provided for NPM7 are for ages 0-9 For ages 10-19, the following objectives are established: 2016-285.0 2017-280.0 2018-275.0 2019-270.0 2020-265.0

**NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester**

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	72.8 %	0.1 %	97,181	133,431
2012	72.8 %	0.1 %	98,877	135,833
2011	72.2 %	0.1 %	98,661	136,706
2010	71.7 %	0.1 %	97,915	136,499
2009	71.6 %	0.1 %	98,769	137,874

**Legends:**  
 Indicator has a numerator <10 and is not reportable  
 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM-1 Notes:**

None

**Data Alerts:**

None

**NOM-2 Rate of severe maternal morbidity per 10,000 delivery hospitalizations**

**Data Source: State Inpatient Databases (SID)**

Multi-Year Trend				

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	128.1	3.1 %	1,707	133,247
2011	118.9	3.0 %	1,604	134,872
2010	108.4	2.8 %	1,466	135,194
2009	110.8	2.8 %	1,529	138,044
2008	102.1	2.7 %	1,408	137,973

**Legends:**

🚫 Indicator has a numerator ≤10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM-2 Notes:**

None

**Data Alerts:**

None

**NOM-3 Maternal mortality rate per 100,000 live births**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	10.6
Numerator	15
Denominator	140,873
Data Source	Pennsylvania Report of Maternal Deaths, Pennsylvania Live Births
Data Source Year	2012

**NOM-3 Notes:**

None

**Data Alerts:**

None

**NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.0 %	0.1 %	11,219	140,081
2012	8.1 %	0.1 %	11,492	141,805
2011	8.2 %	0.1 %	11,662	142,786
2010	8.4 %	0.1 %	11,941	143,006
2009	8.3 %	0.1 %	12,187	146,040

**Legends:**  
 Indicator has a numerator <10 and is not reportable  
 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM-4.1 Notes:**

None

**Data Alerts:**

None

**NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.4 %	0.0 %	2,006	140,081
2012	1.5 %	0.0 %	2,137	141,805
2011	1.5 %	0.0 %	2,151	142,786
2010	1.6 %	0.0 %	2,309	143,006

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	1.6 %	0.0 %	2,347	146,040

**Legends:**

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM-4.2 Notes:**

None

**Data Alerts:**

None

**NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.6 %	0.1 %	9,213	140,081
2012	6.6 %	0.1 %	9,355	141,805
2011	6.7 %	0.1 %	9,511	142,786
2010	6.7 %	0.1 %	9,632	143,006
2009	6.7 %	0.1 %	9,840	146,040

**Legends:**

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM-4.3 Notes:**

None

**Data Alerts:**

None

**NOM-5.1 Percent of preterm births (<37 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	9.4 %	0.1 %	13,066	139,775
2012	9.5 %	0.1 %	13,407	141,341
2011	9.6 %	0.1 %	13,575	142,053
2010	9.9 %	0.1 %	14,060	142,174
2009	10.1 %	0.1 %	14,592	144,968

**Legends:**  
 Indicator has a numerator <10 and is not reportable  
 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM-5.1 Notes:**

None

**Data Alerts:**

None

**NOM-5.2 Percent of early preterm births (<34 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.9 %	0.1 %	4,095	139,775
2012	3.0 %	0.1 %	4,245	141,341
2011	3.0 %	0.1 %	4,237	142,053
2010	3.0 %	0.1 %	4,311	142,174

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	3.0 %	0.1 %	4,408	144,968

**Legends:**

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM-5.2 Notes:**

None

**Data Alerts:**

None

**NOM-5.3 Percent of late preterm births (34-36 weeks)**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.4 %	0.1 %	8,971	139,775
2012	6.5 %	0.1 %	9,162	141,341
2011	6.6 %	0.1 %	9,338	142,053
2010	6.9 %	0.1 %	9,749	142,174
2009	7.0 %	0.1 %	10,184	144,968

**Legends:**

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM-5.3 Notes:**

None

**Data Alerts:**

None

**NOM-6 Percent of early term births (37, 38 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	21.8 %	0.1 %	30,426	139,775
2012	22.3 %	0.1 %	31,448	141,341
2011	22.9 %	0.1 %	32,491	142,053
2010	23.9 %	0.1 %	33,955	142,174
2009	24.5 %	0.1 %	35,533	144,968

**Legends:**  
📄 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM-6 Notes:**

None

**Data Alerts:**

None

**NOM-7 Percent of non-medically indicated early elective deliveries**

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	4.0 %			

**Legends:**  
📄 Indicator results were based on a shorter time period than required for reporting

**NOM-7 Notes:**

None

**Data Alerts:**

None

**NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.1	0.2 %	1,007	141,349
2012	7.9	0.2 %	1,134	143,037
2011	6.9	0.2 %	996	143,631
2010	7.5	0.2 %	1,078	143,812
2009	7.3	0.2 %	1,065	146,899

**Legends:**  
🚫 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM-8 Notes:**

None

**Data Alerts:**

None

**NOM-9.1 Infant mortality rate per 1,000 live births**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.7	0.2 %	937	140,921

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	7.1	0.2 %	1,005	142,514
2011	6.5	0.2 %	929	143,178
2010	7.2	0.2 %	1,036	143,321
2009	7.1	0.2 %	1,040	146,434

**Legends:**

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM-9.1 Notes:**

None

**Data Alerts:**

None

**NOM-9.2 Neonatal mortality rate per 1,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.8	0.2 %	679	140,921
2012	5.0	0.2 %	715	142,514
2011	4.5	0.2 %	646	143,178
2010	5.1	0.2 %	734	143,321
2009	4.9	0.2 %	720	146,434

**Legends:**

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM-9.2 Notes:**

None

**Data Alerts:**

None

### NOM-9.3 Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.8	0.1 %	258	140,921
2012	2.0	0.1 %	290	142,514
2011	2.0	0.1 %	283	143,178
2010	2.1	0.1 %	302	143,321
2009	2.2	0.1 %	320	146,434

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

### NOM-9.3 Notes:

None

### Data Alerts:

None

### NOM-9.4 Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	281.0	14.1 %	396	140,921
2012	287.0	14.2 %	409	142,514
2011	263.3	13.6 %	377	143,178

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010	290.3	14.3 %	416	143,321
2009	295.0	14.2 %	432	146,434

**Legends:**

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM-9.4 Notes:**

None

**Data Alerts:**

None

**NOM-9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	83.7	7.7 %	118	140,921
2012	88.4	7.9 %	126	142,514
2011	85.9	7.8 %	123	143,178
2010	99.1	8.3 %	142	143,321
2009	106.5	8.5 %	156	146,434

**Legends:**

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM-9.5 Notes:**

None

**Data Alerts:**

None

**NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	7.5 %	0.9 %	10,214	135,619
2010	7.0 %	0.9 %	9,487	135,581
2009	7.1 %	0.9 %	9,803	138,011
2008	7.1 %	0.9 %	9,894	139,733
2007	6.1 %	1.3 %	5,129	83,516

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

**NOM-10 Notes:**

None

**Data Alerts:**

None

**NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations**

Data Source: State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	16.5	0.4 %	2,199	133,249
2011	13.6	0.3 %	1,827	134,872
2010	11.2	0.3 %	1,519	135,194
2009	9.6	0.3 %	1,324	138,044

Year	Annual Indicator	Standard Error	Numerator	Denominator
2008	8.2	0.2 %	1,132	137,974

**Legends:**

🚫 Indicator has a numerator ≤10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM-11 Notes:**

None

**Data Alerts:**

None

**NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)**

**FAD Not Available for this measure.**

**NOM-12 Notes:**

None

**Data Alerts:**

None

**NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)**

**FAD Not Available for this measure.**

**NOM-13 Notes:**

None

**Data Alerts:**

None

**NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months**

**Data Source: National Survey of Children’s Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.7 %	1.6 %	517,530	2,624,270

**Legends:**

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM-14 Notes:**

None

**Data Alerts:**

None

**NOM-15 Child Mortality rate, ages 1 through 9 per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	15.5	1.1 %	204	1,319,788
2012	17.2	1.1 %	228	1,327,819
2011	16.4	1.1 %	218	1,329,111
2010	14.8	1.1 %	198	1,341,623
2009	16.7	1.1 %	223	1,338,778

**Legends:**

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM-15 Notes:**

None

**Data Alerts:**

None

**NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	29.4	1.4 %	476	1,618,822
2012	32.5	1.4 %	534	1,644,941
2011	32.1	1.4 %	536	1,671,249
2010	34.0	1.4 %	576	1,696,217
2009	31.6	1.4 %	541	1,713,734

**Legends:**  
 Indicator has a numerator <10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

**NOM-16.1 Notes:**

None

**Data Alerts:**

None

**NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	12.6	0.7 %	328	2,600,002
2010_2012	14.2	12.8 %	378	2,657,908
2009_2011	14.2	12.8 %	385	2,708,142
2008_2010	14.8	13.4 %	406	2,743,868
2007_2009	16.5	15.0 %	456	2,761,043

**Legends:**

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM-16.2 Notes:**

None

**Data Alerts:**

None

**NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	7.6	6.6 %	198	2,600,002
2010_2012	7.5	6.5 %	200	2,657,908
2009_2011	7.5	6.5 %	204	2,708,142
2008_2010	7.0	6.0 %	192	2,743,868
2007_2009	6.1	5.2 %	169	2,761,043

**Legends:**

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM-16.3 Notes:**

None

**Data Alerts:**

None

**NOM-17.1 Percent of children with special health care needs**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend
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Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	22.3 %	1.5 %	614,207	2,752,138
2007	20.9 %	1.6 %	583,332	2,794,078
2003	18.9 %	1.0 %	533,166	2,815,445

**Legends:**

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM-17.1 Notes:**

None

**Data Alerts:**

None

**NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system**

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	21.4 %	2.0 %	93,556	436,844

**Legends:**

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM-17.2 Notes:**

None

**Data Alerts:**

None

**NOM-17.3 Percent of children diagnosed with an autism spectrum disorder**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	2.3 %	0.5 %	53,554	2,324,035
2007	1.8 %	0.7 %	42,832	2,347,841

**Legends:**

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM-17.3 Notes:**

None

**Data Alerts:**

None

**NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	9.2 %	1.2 %	213,543	2,315,341
2007	7.4 %	1.2 %	174,425	2,346,984

**Legends:**

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM-17.4 Notes:**

None

**Data Alerts:**

None

**NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	69.1 % ⚡	5.5 % ⚡	193,172 ⚡	279,708 ⚡
2007	81.3 %	4.7 %	217,274	267,200
2003	76.4 %	3.7 %	148,118	193,991

**Legends:**  
 🚩 Indicator has an unweighted denominator <30 and is not reportable  
 ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM-18 Notes:**

None

**Data Alerts:**

None

**NOM-19 Percent of children in excellent or very good health**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	87.3 %	1.3 %	2,400,525	2,749,015
2007	88.7 %	1.2 %	2,478,407	2,794,078
2003	87.4 %	0.9 %	2,460,765	2,815,445

**Legends:**  
 🚩 Indicator has an unweighted denominator <30 and is not reportable  
 ⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM-19 Notes:**

None

**Data Alerts:**

None

**NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.5 %	2.3 %	321,906	1,215,876
2007	29.7 %	2.4 %	376,361	1,268,280
2003	29.3 %	1.7 %	390,055	1,332,616

**Legends:**  
📌 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: WIC**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	28.4 %	0.2 %	26,380	93,040

**Legends:**  
📌 Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable  
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: Youth Risk Behavior Surveillance System (YRBSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	27.5 %	1.1 %	154,056	559,897

Year	Annual Indicator	Standard Error	Numerator	Denominator
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**Legends:**

-  Indicator has an unweighted denominator <100 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM-20 Notes:**

None

**Data Alerts:**

None

**NOM-21 Percent of children without health insurance**

**Data Source: American Community Survey (ACS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.0 %	0.2 %	134,993	2,709,009
2012	5.1 %	0.3 %	139,286	2,732,366
2011	5.4 %	0.3 %	148,564	2,758,314
2010	5.3 %	0.3 %	146,737	2,785,072
2009	5.0 %	0.3 %	138,132	2,770,999

**Legends:**

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM-21 Notes:**

None

**Data Alerts:**

None

**NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine**

vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	75.5 %	2.7 %	157,582	208,695
2012	68.3 %	3.0 %	143,464	210,027
2011	69.7 %	2.5 %	148,434	212,970
2010	61.3 %	2.7 %	132,844	216,692
2009	38.8 %	3.1 %	84,163	217,080

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM-22.1 Notes:**

None

**Data Alerts:**

None

**NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	59.8 %	1.8 %	1,558,312	2,604,570
2012_2013	64.9 %	2.5 %	1,674,796	2,581,443
2011_2012	54.8 %	1.9 %	1,417,118	2,586,916
2010_2011	58.3 %	2.3 %	1,483,616	2,544,796
2009_2010	47.8 %	1.9 %	1,277,497	2,672,587

**Legends:**

📌 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM-22.2 Notes:**

None

**Data Alerts:**

None

**NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine**

Data Source: National Immunization Survey (NIS) - Female

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	59.5 %	4.1 %	229,756	386,058
2012	57.4 %	4.1 %	223,164	388,522
2011	51.9 %	4.1 %	204,680	394,084
2010	52.3 %	3.9 %	211,177	404,115
2009	53.2 %	4.8 %	215,713	405,598

**Legends:**

📌 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	44.1 %	4.0 %	179,131	406,034
2012	21.9 %	3.1 %	89,702	409,792

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	8.5 %	1.9 %	35,326	415,205

**Legends:**

📌 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM-22.3 Notes:**

None

**Data Alerts:**

None

**NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine**

Data Source: National Immunization Survey (NIS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	89.9 %	1.8 %	711,883	792,092
2012	88.4 %	1.8 %	705,991	798,314
2011	81.0 %	2.2 %	655,887	809,289
2010	74.0 %	2.5 %	613,378	829,381
2009	67.9 %	3.0 %	565,784	833,340

**Legends:**

📌 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM-22.4 Notes:**

None

**Data Alerts:**

None

**NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	90.4 %	1.8 %	716,165	792,092
2012	89.4 %	1.8 %	713,612	798,314
2011	83.8 %	2.1 %	678,342	809,289
2010	79.8 %	2.3 %	661,919	829,381
2009	71.9 %	3.0 %	599,084	833,340

**Legends:**

- 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM-22.5 Notes:**

None

**Data Alerts:**

None

**Form 10a**  
**National Performance Measures (NPMs)**  
**State: Pennsylvania**

**NPM-1 Percent of women with a past year preventive medical visit**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	68.0	68.7	69.4	70.1	71.4

**NPM-4 A) Percent of infants who are ever breastfed**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	74.0	76.0	78.0	80.0	82.0

**NPM-4 B) Percent of infants breastfed exclusively through 6 months**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	17.0	18.0	20.0	23.0	26.0

**NPM-5 Percent of infants placed to sleep on their backs**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.2	79.0	79.8	80.6	82.1

**NPM-7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	188.7	186.8	184.9	183.1	179.3

**NPM-9 Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14.5	14.3	14.1	13.9	13.7

**NPM-10 Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	86.9	87.8	88.7	89.6	91.2

**NPM-11 Percent of children with and without special health care needs having a medical home**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.0	50.5	51.0	51.5	52.5

**NPM-14 A) Percent of women who smoke during pregnancy**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14.0	13.7	13.2	13.0	12.8

**NPM-14 B) Percent of children who live in households where someone smokes**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	28.3	27.3	26.3	25.3	24.3

**Form 10b**  
**State Performance/Outcome Measure Detail Sheet**  
**State: Pennsylvania**

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

**Form 10c**  
**Evidence-Based or Informed Strategy Measure Detail Sheet**  
**State: Pennsylvania**

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

**Form 10d**  
**National Performance Measures (NPMs) (Reporting Year 2014 & 2015)**  
**State: Pennsylvania**

**Form Notes for Form 10d NPMs and SPMs**

None

**NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.**

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	289	243	294	185	
Denominator	289	243	294	185	
Data Source	See field level note	See field level note	Division of Newborn Screening and Genetics	Division of Newborn Screening and Genetics	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b> Source: Division of Newborn Screening and Genetics	
2.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b> Source: PA Department of Health, Bureau of Health Statistics and Research	

**Data Alerts:**

None

**NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)**

	2011	2012	2013	2014	2015
Annual Objective	60.6	73.1	73.1	73.1	77.8
Annual Indicator	73.1	73.1	73.1	73.1	
Numerator					
Denominator					
Data Source	See field level note				
Provisional Or Final ?				Provisional	

#### Field Level Notes for Form 10d NPMs:

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes. For 2012-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2012-2013. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2012-2013 there were wording changes and additions to the questions used to generate this indicator. The data for 2012-2013 and later are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes. For 2012-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2012-2013. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2012-2013 there were wording changes and additions to the questions used to generate this indicator. The data for 2012-2013 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were

wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts:**

None

**NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	45.8	48.0	48.0	48.0	51.1
Annual Indicator	45.8	48.0	48.0	48.0	
Numerator					
Denominator					
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania’s past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes.

For 2012-2015, indicator data come from the National Survey of Children with Special Health Care Needs

(CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2012-2013. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** 2013

**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes.

For 2012-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2012-2013. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** 2012

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** 2011

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts:**

None

**NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	66.2	69.0	69.0	69.0	73.4
Annual Indicator	66.2	69.0	69.0	69.0	
Numerator					
Denominator					
Data Source	See field Level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania’s past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes.

For 2012-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2012-2013. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania’s past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes.

For 2012-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2012-2013. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs

(CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts:**

None

**NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	89.5	69.4	69.4	69.4	74.6
Annual Indicator	69.4	69.4	69.4	69.4	
Numerator					
Denominator					
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes.

For 2012-2015, indicator data come from the National Survey of Children with Special Health Care Needs

(CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** 2013

**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes.

For 2012-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** 2012

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** 2011

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts:**

None

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**NPM 06 - The percentage of youth with special health care needs who received the services necessary to make**

**transitions to all aspects of adult life, including adult health care, work, and independence.**

	2011	2012	2013	2014	2015
Annual Objective	46.0	40.0	40.0	40.0	40.0
Annual Indicator	40.0	40.0	40.0	40.0	
Numerator					
Denominator					
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania’s past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes.

For 2012-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania’s past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes.

For 2012-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts:**

None

**NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.**

	2011	2012	2013	2014	2015
Annual Objective	80.0	80.0	80.0	80.0	80.0
Annual Indicator	76.9	73.4	81.9	0.0	
Numerator					
Denominator					
Data Source	See field level note				
Provisional Or				Provisional	

	2011	2012	2013	2014	2015
Final ?					

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**  
2014 data not available.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**  
The Annual Indicators were obtained from the National Immunization Survey conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. Data are for children 19-35 months of age. Numerators and denominators are not available. 2013 should be in this form 81.9+-5.4

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**  
The Annual Indicators were obtained from the National Immunization Survey conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. Data are for children 19-35 months of age. Numerators and denominators are not available. 2012 should be in this form 72.3+-6.7

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**  
The Annual Indicators were obtained from the National Immunization Survey conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. Data are for children 19-35 months of age. Numerators and denominators are not available. 2011 should be in this form 76.9+-4.6

**Data Alerts:**

None

**NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.**

	2011	2012	2013	2014	2015
Annual Objective	14.5	14.4	14.4	14.3	14.3
Annual Indicator	13.0	11.9	10.1	0.0	
Numerator	3,147	2,846	2,383		
Denominator	242,973	238,367	235,476		
Data Source	See field level note				

	2011	2012	2013	2014	2015
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Source: PA Department of Health, Division of Health Informatics Denominator source: PA State Data Center

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Numerator source: PA Department of Health, Bureau of Health Statistics and Research  
Denominator source: PA State Data Center

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Numerator source: PA Department of Health, Bureau of Health Statistics and Research  
Denominator source: PA State Data Center

**Data Alerts:**

None

**NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.**

	2011	2012	2013	2014	2015
Annual Objective	27.5	27.5	28.0	28.0	28.0
Annual Indicator	33.2	40.2	16.4	17.8	
Numerator	23,017	25,160	10,365	11,522	
Denominator	69,329	62,524	63,163	64,782	
Data Source	See field level note				
Provisional Or				Provisional	

	2011	2012	2013	2014	2015
Final ?					

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/13 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the number of Medicaid enrollees who are 8 years old as of 09/30/13. Source: PA Department of Public Welfare

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/12 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the number of Medicaid enrollees who are 8 years old as of 09/30/12. Source: PA Department of Public Welfare

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/11 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the number of Medicaid enrollees who are 8 years old as of 09/30/11. Source: PA Department of Public Welfare

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/10 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the number of Medicaid enrollees who are 8 years old as of 09/30/10. Source: PA Department of Public Welfare

**Data Alerts:**

None

**NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.**

	2011	2012	2013	2014	2015
Annual Objective	1.9	1.8	1.7	1.6	1.5
Annual Indicator	1.2	1.6	1.6	0.0	
Numerator	27	35	35		
Denominator	2,257,025	2,247,153	2,234,011		

	2011	2012	2013	2014	2015
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

Data Not available. Usually these data are available 12 to 18 months from the close of the calendar year.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Source: PA Department of Health, Division of Health Informatics Denominator source: PA State Data Center

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Numerator source: PA Department of Health, Bureau of Health Statistics and Research  
Denominator source: PA State Data Center

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Numerator source: PA Department of Health, Bureau of Health Statistics and Research  
Denominator source: PA State Data Center

**Data Alerts:**

None

**NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.**

	2011	2012	2013	2014	2015
Annual Objective	37.5	37.5	44.0	46.0	48.0
Annual Indicator			0.0	0.0	
Numerator					
Denominator					
Data Source	See field level note				

	2011	2012	2013	2014	2015
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes. These data are collected over a 3 year period and final data area available 4 years from date of birth.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes. These data are collected over a 3 year period and final data area available 4 years from date of birth.

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

A new data source is being utilized beginning with the revision of the 2008 data. These data are collected over a 3-year period and final data are available 4 years from date of birth.

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

2008 birth data should become available in 2011/2012. Data delay as CDC is developing a new system of data collection by year of birth. These data are collected over a 3-yr period and final data are available 4 yrs from date of birth.

**Data Alerts:**

None

**NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.**

	2011	2012	2013	2014	2015
Annual Objective	98.5	98.6	98.7	97.2	98.7
Annual Indicator	98.7	97.8	98.8	98.3	
Numerator	136,503	134,493	133,796	133,595	
Denominator	138,255	137,524	135,408	135,943	

	2011	2012	2013	2014	2015
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

Numerator source: Division of Newborn Screening and Genetics Denominator source: PA Department of Health, Bureau of Health Statistics and Research

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Numerator source: Division of Newborn Screening and Genetics  
Denominator source: PA Department of Health, Bureau of Health Statistics and Research

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Numerator source: Division of Newborn Screening and Genetics  
Denominator source: PA Department of Health, Bureau of Health Statistics and Research

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Numerator source: Division of Newborn Screening and Genetics  
Denominator source: PA Department of Health, Bureau of Health Statistics and Research

**Data Alerts:**

None

**NPM 13 - Percent of children without health insurance.**

	2011	2012	2013	2014	2015
Annual Objective	6.7	6.5	6.5	6.5	6.4
Annual Indicator	7.6	7.7	7.8	0.0	
Numerator	206,000	212,000	212,000		
Denominator	2,710,508	2,755,000	2,708,843		

	2011	2012	2013	2014	2015
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

Data not available. 2014 will not be available until September of 2015.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Percent and denominator are from Table HI-5, Health Insurance Coverage Status and Type of Coverage by State, Children Under 18, prepared by the U.S. Census Bureau. The numerator was calculated using the data from Table HI-5. PA has chosen to use the U.S. Census Bureau data because we believe it is the most consistent, reliable, and objective data available to us.

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Percent and denominator are from Table HI-5, Health Insurance Coverage Status and Type of Coverage by State, Children Under 18, prepared by the U.S. Census Bureau. The numerator was calculated using the data from Table HI-5. PA has chosen to use the U.S. Census Bureau data because we believe it is the most consistent, reliable, and objective data available to us.

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Percent and denominator are from Table HI-5, Health Insurance Coverage Status and Type of Coverage by State, Children Under 18, prepared by the U.S. Census Bureau. The numerator was calculated using the data from Table HI-5. PA has chosen to use the U.S. Census Bureau data because we believe it is the most consistent, reliable, and objective data available to us.

**Data Alerts:**

None

**NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.**

	2011	2012	2013	2014	2015
Annual Objective	19.0	18.0	17.0	16.0	16.0

	2011	2012	2013	2014	2015
Annual Indicator	27.3		0.0	0.0	
Numerator	32,810				
Denominator	120,182				
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

Source: CDC Pediatric Nutrition Surveillance System The CDC discontinued the production of the Pediatric Nutrition Surveillance System (PedNSS) reports in 2012. Efforts to replicate the reports formerly provided by CDC were unsuccessful due to a switch in maintenance and support contractors for the current QuickWIC system. This data is not currently available.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Source: CDC Pediatric Nutrition Surveillance System  
The CDC discontinued the production of the Pediatric Nutrition Surveillance System (PedNSS) reports in 2012. Efforts are under way to replicate the data scrubbing of raw data from the QuickWIC system to replicate the reports. The estimated timeline for being able to reproduce the reports is Spring 2014. An extract of 2012 data has been captured, but until it can be analyzed, there are no new comparable rates that can be used for this performance measure.

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Source: CDC Pediatric Nutrition Surveillance System  
The CDC discontinued the production of the Pediatric Nutrition Surveillance System (PedNSS) reports in 2012. Efforts are under way to replicate the data scrubbing of raw data from the QuickWIC system to replicate the reports. The estimated timeline for being able to reproduce the reports is Spring 2014. An extract of 2012 data has been captured, but until it can be analyzed, there are no new comparable rates that can be used for this performance measure.

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Source: CDC Pediatric Nutrition Surveillance System

**Data Alerts:**

None

**NPM 15 - Percentage of women who smoke in the last three months of pregnancy.**

	2011	2012	2013	2014	2015
Annual Objective	12.8	12.5	12.2	11.9	11.8
Annual Indicator	11.8	11.5	11.1	0.0	
Numerator	16,443	15,803	15,127		
Denominator	138,852	137,781	136,063		
Data Source	See field level note	See field level note	PA Department of Health, Division of Health Informatics	PA Department of Health, Division of Health Informatics	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	provisional data
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Unknowns excluded in calculations. Source: PA Department of Health, Bureau of Health Statistics
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Unknowns excluded in calculations. Source: PA Department of Health, Bureau of Health Statistics

**Data Alerts:**

None

**NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.**

	2011	2012	2013	2014	2015
Annual Objective	6.0	6.0	6.0	6.0	6.0
Annual Indicator	7.7	6.5	7.9	0.0	
Numerator	68	56	67		
Denominator	886,367	866,475	847,160		
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Source: PA Department of Health, Division of Health Informatics Denominator source: PA State Data Center
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Numerator source: PA Department of Health, Bureau of Health Statistics and Research Denominator source: PA State Data Center
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Numerator source: PA Department of Health, Bureau of Health Statistics and Research Denominator source: PA State Data Center

**Data Alerts:**

None

**NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.**

	2011	2012	2013	2014	2015
Annual Objective	82.9	82.9	82.9	82.9	82.9

	2011	2012	2013	2014	2015
Annual Indicator	85.8	87.6	81.3	0.0	
Numerator	1,852	1,896	1,640		
Denominator	2,159	2,165	2,018		
Data Source	See field level note	See field level note	PA Department of Health, Division of Health Informatics	See field level note	
Provisional Or Final ?				Provisional	

#### Field Level Notes for Form 10d NPMs:

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.
2.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Source: PA Department of Health, Bureau of Health Statistics and Research
3.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Source: PA Department of Health, Bureau of Health Statistics and Research

#### Data Alerts:

None

#### NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	72.0	72.0	72.0	72.0	72.0
Annual Indicator	71.7	72.4	69.1	0.0	
Numerator	97,796	97,802	95,811		
Denominator	136,401	134,995	138,612		
Data Source	See field level note				

	2011	2012	2013	2014	2015
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Unknowns excluded in calculations. Source: PA Department of Health, Division of Health Informatics

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Unknowns excluded in calculations.  
Source: PA Department of Health, Bureau of Health Statistics and Research

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Unknowns excluded in calculations.  
Source: PA Department of Health, Bureau of Health Statistics and Research

**Data Alerts:**

None

**Form 10d**  
**State Performance Measures (SPMs) (Reporting Year 2014 & 2015)**  
**State: Pennsylvania**

**SPM 1 - Percent of women (15 through 44) with a live birth whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck index.**

	2011	2012	2013	2014	2015
Annual Objective	66.9	66.9	66.9	71.9	70.0
Annual Indicator	69.3	71.4	71.7	0.0	
Numerator	91,222	93,917	92,788		
Denominator	131,602	131,536	129,486		
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Calculated with missing data (adequacy measure could not be computed) removed from denominator. Source: PA Department of Health, Division of Health Informatics
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Calculated with missing data (adequacy measure could not be computed) removed from denominator. Source: PA Department of Health, Bureau of Health Statistics and Research
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Calculated with missing data (adequacy measure could not be computed) removed from denominator. Source: PA Department of Health, Bureau of Health Statistics and Research

**Data Alerts:**

None

**SPM 2 - Black infant mortality rate per 1,000 live births.**

	2011	2012	2013	2014	2015
Annual Objective	16.6	16.6	16.5	14.0	16.4
Annual Indicator	13.7	14.1	13.7	0.0	
Numerator	294	301	273		
Denominator	21,395	21,382	19,866		
Data Source	See field level note	See field level note	PA Department of Health, Division of Health Informatics	See field level note	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.
2.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Source: PA Department of Health, Bureau of Health Statistics and Research
3.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Source: PA Department of Health, Bureau of Health Statistics and Research

**Data Alerts:**

None

**SPM 3 - Percent of women receiving WIC services screened for behavioral health concerns (through MCH consultants or state health nurses) at participating WIC clinics and/or their umbrella agencies.**

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	0.0	0.0
Annual Indicator			0.0	0.0	

	2011	2012	2013	2014	2015
Numerator	0	0			
Denominator					
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**  
No data are available. Program in development

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**  
No data are available. Program in development

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**  
Data not available. Program in development

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**  
Data not available. Program in development

**Data Alerts:**

1.	A value of zero has been entered for the numerator for year 2011 SPM# 3. Please review your data to ensure this is correct.
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2.	A value of zero has been entered for the numerator for year 2012 SPM# 3. Please review your data to ensure this is correct.
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**SPM 4 - Rate of pregnancy per 1,000 females ages 17 and under.**

	2011	2012	2013	2014	2015

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	7.9	7.0	7.9
Annual Indicator	8.0	7.1	6.8	0.0	
Numerator	4,989	4,406	4,139		
Denominator	626,594	618,298	608,366		
Data Source	See field level note	See field level note	Pennsylvania Department of Health, Division of Health Informatics	See field level note	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	provisional data
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Numerator source: PA Department of Health, Bureau of Health Statistics and Research Denominator source: PA State Data Center
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Numerator source: PA Department of Health, Bureau of Health Statistics and Research Denominator source: PA State Data Center

**Data Alerts:**

None

**SPM 5 - Percent of infants and children (1-5) receiving WIC services screened for mental health concerns (through MCH consultants/state health nurses) at participating WIC clinics or their umbrella agencies.**

	2011	2012	2013	2014	2015
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	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	0.0	0.0
Annual Indicator			0.0	0.0	
Numerator	0	0			
Denominator					
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Data are not available. Programming still in development
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Data are not available. Programming still in development.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Data are not available. Programming still in development.
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Data are not available. Programming still in development.

**Data Alerts:**

1.	A value of zero has been entered for the numerator for year 2011 SPM# 5. Please review your data to ensure this is correct.
2.	A value of zero has been entered for the numerator for year 2012 SPM# 5. Please review your data to ensure this is correct.

**SPM 6 - Percent of youth serving health, mental health, and drug and alcohol clinics that target LGBTQ, runaway or**

**homeless youth.**

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	0.0	0.0
Annual Indicator			0.0	0.0	
Numerator	0	0			
Denominator					
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Data are not available. Program in implementation stage
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Data are not available. Program in implementation stage
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Data are not available. Program in implementation stage
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Data are not available. Program in implementation stage

**Data Alerts:**

1.	A value of zero has been entered for the numerator for year 2011 SPM# 6. Please review your data to ensure this is correct.
2.	A value of zero has been entered for the numerator for year 2012 SPM# 6. Please review your data to ensure this is correct.

**SPM 7 - The death rate per 100,000 due to unintentional injuries among children aged 19 years and younger**

	2011	2012	2013	2014	2015
Annual Objective	9.6	9.5	9.5	9.1	9.5
Annual Indicator	10.6	9.3	9.6	0.0	
Numerator	333	290	296		
Denominator	3,143,392	3,113,628	3,081,171		
Data Source	See field level note	See field level note	PA Department of Health, Division of Health Informatics	See field level note	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.
2.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Numerator source: PA Department of Health, Bureau of Health Statistics and Research Denominator source: PA State Data Center
3.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Numerator source: PA Department of Health, Bureau of Health Statistics and Research Denominator source: PA State Data Center

**Data Alerts:**

None

**SPM 8 - Percent of children with special health care needs (CSHCN) needing a referral for specialty care/services in the last 12 months and had no problems getting it.**

	2011	2012	2013	2014	2015
Annual Objective	89.5	82.8	82.8	82.8	86.3
Annual Indicator	82.8	82.8	82.8	82.8	

	2011	2012	2013	2014	2015
Numerator		130,892			
Denominator		158,083			
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes. For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Source for 2013: 2009/10 National Survey of Children with Special Health Care Needs

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes.

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

Source for 2013: 2009/10 National Survey of Children with Special Health Care Needs

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. The annual performance objective for this measure has been set to match the annual indicator from 2012 and will remain at that level until another CSHCN survey is conducted.

Source for 2012: 2009/10 National Survey of Children with Special Health Care Needs

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. The annual performance objective for this measure has been set to match the annual indicator from 2011 and will remain at that level until another CSHCN survey is conducted.

**Data Alerts:**

None

**SPM 9 - The percentage of youth with special health care needs (YSHCN) who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.**

	2011	2012	2013	2014	2015
Annual Objective	46.0	40.0	40.0	40.0	44.4
Annual Indicator	40.0	40.0	40.0	40.0	
Numerator		78,269			
Denominator		195,595			
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes. For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Source for 2013: 2009/10 National Survey of Children with Special Health Care Needs

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes.

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.  
Source for 2013: 2009/10 National Survey of Children with Special Health Care Needs

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. The annual performance objective for this measure has been set to match the annual indicator from 2012 and will remain at that level until another CSHCN survey is conducted.

Source for 2012: 2009/10 National Survey of Children with Special Health Care Needs

4. **Field Name:** 2011

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. The annual performance objective for this measure has been set to match the annual indicator from 2011 and will remain at that level until another CSHCN survey is conducted.

Source for 2011: 2009/10 National Survey of Children with Special Health Care Needs

**Data Alerts:**

None

**SPM 10 - Percent of families with children with special health care needs (CSHCN) who received all the respite care that was needed during the past 12 months.**

	2011	2012	2013	2014	2015
Annual Objective	59.4	58.8	58.8	58.8	60.6
Annual Indicator	58.8	40.0	58.8	58.8	
Numerator		78,269			
Denominator		195,595			
Data Source	See field level note				
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2014

**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes. For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Source for 2014: 2009/10 National Survey of Children with Special Health Care Needs

2. **Field Name:** 2013

**Field Note:**

General Note: Annual Performance Objectives were developed to capture Pennsylvania's past successes and better reflect the work taking place under this measure with the anticipation of improved outcomes.

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

Source for 2013: 2009/10 National Survey of Children with Special Health Care Needs

3. **Field Name:** 2012

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. The annual performance objective for this measure has been set to match the annual indicator from 2012 and will remain at that level until another CSHCN survey is conducted.

Source for 2012: 2009/10 National Survey of Children with Special Health Care Needs

4. **Field Name:** 2011

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. The annual performance objective for this measure has been set to match the annual indicator from 2011 and will remain at that level until another CSHCN survey is conducted.

Upon review of this year's application, a change needed to be made the Annual Performance indicator for 2011, however, attempts to make that change electronically were not successful. The Annual Performance indicator for 2011 should read 58.8.

Source for 2011: 2009/10 National Survey of Children with Special Health Care Needs

**Data Alerts:**

None

**Form 11**  
**Other State Data**  
**State: Pennsylvania**

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

## State Action Plan Table

State: Pennsylvania

Please click the link below to download a PDF of the State Action Plan Table.

[State Action Plan Table](#)